THE LANCET.

LECTURES

ON THE

ANATOMY, PHYSIOLOGY, AND DISEASES OF THE EYE.

By MR. LAWRENCE.

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LECTURE XXVIII.

Cataract—continued.

Gentlemen,

The success of surgical operations depends, in many cases, on preventing the subsequent occurrence of inflammation, and in no case is this more important than in cataract. Hence it is very necessary, not only to discriminate the several kinds of cataract, and know the operation best fitted for each, but also to inquire into the patient's health, and bring it into the state most favourable for operation.

The question is, what kind of preparation is necessary? One rule is very obvious; that is, not to operate on a patient with a foul tongue. A clean tongue shows that the alimentary canal is in a healthy state, and consequently leads us to a favourable conclusion as to the general health. No fermented liquors, and generally no animal food, should be taken for a week or fortnight previously; and the bowels should be evacuated by some mild aperient every other day during this time: they should also be well cleared on the morning of the operation. These remarks will apply to all cases; and, generally speaking, this is the only preparation necessary. Some cases, however, require further preparatory measures; in plethoric subjects, and such as manifest great determination of blood to the head, direct depletion is necessary. In robust persons, in those about the middle period of life, it will be necessary to resort to venesection; and if the pulse were full, and the patient young and strong, it might be advisable to take blood freely and repeatedly before operating. In general it is sufficient to take some blood from the arm, on the morning of the operation. In persons of a decided plethoric habit, with symptoms of determination to the head, you must practise active depletion; and this is occasionally necessary even in old persons. I remember, at the Infirmary, the case of a woman, seventy years of age, who had amaurosis of one eye and cataract in the other; she was corpulent, with a full, bloated, and reddish countenance. She complained particularly of what she called weakness and nervousness, which she had endeavoured to counteract by the free use of animal food, porter, and other stimulants. She had considerable head-ache, with trembling hands and infirm legs; she was bled from the arm, the blood being strongly buffed and cupped. The head-ache and the nervousness were diminished by the bleeding, and she felt stronger. We kept her here fourteen days before she was in a fit state to undergo the operation; and during that time she was bled four times, the three first portions of blood being buffed and cupped, and the last free from these appearances. In addition to this direct depletion she was well purged, and kept on broth and gruel, with bread. After about a fortnight's discipline of that kind I operated on the eye, and extracted the cataract, from which she recovered without one untoward symptom, and regained excellent sight. Another patient, who came into the Infirmary to be operated on, and who exhibited the highest degree of general plethora and particular determination to the head, was obliged to lose nearly 120 ounces of blood before he was in a fit state for the operation. He had not an uneasy feeling afterwards, and his recovery was rapid and perfect. These are examples of the preparatory measures, which you may find it necessary to

adopt in particular instances. The great risk of failure is from the occurrence of inflammation; and, in a matter of so much consequence, it is better to err on the side of caution. In some cases I have regretted that I had not attended sufficiently to these preparatory measures; but I have never seen reason to consider them superfluous or injurious.

The next point for consideration is the choice of the operation. From the time of Celsus, in whose work we find the earliest account of any operation for cataract, until the last century, there was only one operation practised, and that consisted in introducing a small needle into the eye behind the iris, and pushing the lens downwards and backwards out of the axis of vision. That operation, inasmuch as it displaces the lens downwards, has been called *depression*. It is accurately described by Celsus, and his manner of performing it is nearly the same as that now practised. About the middle of the last century it happened, in consequence of an opaque lens having escaped through the pupil into the anterior chamber, that Daviel, a French surgeon, thought of making a cut through the cornea to let it out, which he did. Hence he was led to propose and practise generally this method of removing an opaque lens from the eye, which has since been called *extraction*, and much improved. This operation consists in making an incision through the cornea, lacerating the crystalline capsule, and forcing the lens out through the pupil and the opening made in the cornea. When this operation was introduced, a controversy arose as to the merits of the two operations, of extraction and depression, each of which had its warm advocates. The writers on this part of surgery have frequently drawn up, in parallel columns, the advantages and disadvantages of the two methods, and have generally endeavoured to demonstrate the superiority either of extraction or depression, as if it were necessary to choose one or the other, and practise it exclusively. More recently a third mode of operating has been introduced and extensively employed, in which the lens is neither extracted nor depressed, but is disturbed or broken, and left in its place, to be removed by absorption. It is called the operation by *solution* or *absorption*. In this latter mode of proceeding, the needle may be either carried through the cornea and pupil, or be introduced behind the iris, as it is in the operation of depression. These two methods are distinguished by the names of the *anterior* and *posterior* operations. The anterior operation was proposed by a German surgeon, and has been called keratonyxis, a term derived from the Greek, and signifying puncture of the cornea. No person who understands the subject would advise either of these operations to be exclusively employed. Each method has its advantages, and is eligible under certain circumstances; our object then should be, not to select one operation with the view of practising it in all cases, but to consider the circumstances which give a preference to one or the other, and to select in each instance that which is best suited to the particular form of the complaint.

Extraction of the Cataract.

I shall first describe the operation of extraction. I think it best to operate on one eye only at a time. If you restore sight in one, it is sufficient for all useful purposes, and the patient will generally be satisfied: the other may be operated on afterwards, or be retained as a reserve in case the restored sight should fail, or be lost by disease or accident. When both are operated on together, they are not both necessarily involved in any unfavourable subsequent occurrences; yet they are likely to suffer together from common causes, and under such circumstances the patient loses all chance of regaining sight. On the other hand, if things go on unfavourably, it is a great consolation both to the patient and surgeon to know that one eye only is risked.

Extraction may be performed with the patient either sitting or lying: it has been more common to perform it in the former posture. In the operation of extraction it is necessary that the patient should be seated opposite a window which affords a good steady light; a northern aspect is preferable, or at all events, a window should be chosen which does not admit sunshine. If it afford a good light, it is better to have only one window open. The patient should not be seated exactly opposite the window; because the light will be reflected from the centre of the cornea, so as to prevent a clear view of the point of the knife, in its passage across the anterior chamber; to prevent this inconvenience, he should be placed a little obliquely, with the eye to be operated on rather nearer to the window. He should be seated on a chair or stool, rather lower than that occupied by the operator, that the latter may have the free and easy use of his hands and arms, without being obliged to elevate them unpleasantly. The patient may sit on a chair either with a back or without one, but at this

Infirmary, we find the chair with the sliding back the most convenient; you can adjust it very easily to the height of the patient, and rest his head firmly upon it. I think it is a preferable mode to that of fixing the head of the patient against the breast of an assistant; it can be more depended on for steadiness. You may easily adjust your own height by sitting on a music stool, or placing one or more books on the seat of a common chair. The duty of the assistant is to fix the head, to keep it perfectly steady, to elevate the upper lid, and to keep it elevated without pressing on the globe while the section of the cornea is made. If you have a chair with a sliding back, all the assistant has to do is to elevate the lid; but, if you have not a chair so formed, the assistant must fix the patient's head against his own breast by one hand placed under the chin, while he elevates the lid with the other. The assistant should be aware of one point, which should be decided upon between him and the operator before the operation is commenced; namely, to let the lid go before the section of the cornea is completed; and the operator should just give a sign or motion to the assistant as soon as he has nearly finished the section. In elevating the upper lid, one finger is generally sufficient; let the assitant fix the lid against the upper margin of the orbit, the end of the finger being placed on the ciliary margin of the lid: he should firmly hold it against the orbit, until the operator tells him to let it go. It is not material whether the assistant employs his right or left hand; but it will be less in the way if he employ the hand opposite to that which the operator is using. It has been the general practice to bind up the opposite eye, and that was recommended even by Celsus; I believe it is a matter of little consequence. It has been said that if you keep the opposite eye quiet, that which is operated on will remain still also; but I do not find that to be the case. I have found that the best way is to leave the opposite eye open, and direct the patient to look towards the window.

You will meet with descriptions of various instruments for keeping the eye steady, specula of different shapes; they are now entirely abandoned, as not only inefficient but absolutely injurious. Some of these instruments have been made with little hooks intended to be stuck into the sclerotic coat. Figures of such are to be found in Richter's elements of surgery, and in other works. I can conceive nothing more calculated to alarm the patient, to increase spasmodic action of the muscles of the globe, and thus to render the eye unsteady. Hence all contrivances of this sort are now laid aside, and the operator trusts to his own fingers for giving to the globe the necessary degree of steadiness. In accomplishing this point he must act merely on the anterior part of the organ, taking care that no general pressure is made on the globe either by himself or his assistant. Such pressure is most injurious, both by pushing the iris forwards against the cornea, and prematurely forcing out the aqueous humour, and also by endangering the premature and forcible expulsion of the lens, with the vitreous humour.

The operation of extraction consists of *three parts*, the division of the cornea; the laceration of the capsule; and the removal of the lens through the openings made in the capsule and cornea.

The division of the cornea must be ample enough that the lens may escape readily through it; you divide, therefore, a certain portion of the circumference, carrying the section along the edge of the cornea, as near as you can to the sclerotic coat. There are various reasons for making the section at the margin of the cornea, and the principal of these is, that the subsequent cicatrix will not interfere with vision. The section of the cornea must embrace an extent corresponding to the transverse diameter of the lens, and that is nearly equal to the diameter of the cornea itself, so that the section of one half of the cornea is required to allow the lens to escape. You have to divide the inferior half of the cornea; you must puncture it on the temporal side of the eye, carry the knife across the anterior chamber, bring it out at the nasal side opposite to its entrance, and then continue the incision downwards, so that the knife may cut itself out. The chief difficulty in the section of the cornea arises from the iris getting in the way of the knife. When you penetrate the anterior chamber, the aqueous humour readily escapes, and then the iris comes immediately against the knife, so that you cannot carry it on without wounding that part. In order to permit the escape of the aqueous humour, the cornea knives are so shaped as to fill up the wound; that is, they increase in thickness very gradually from the point to the handle.

A great variety of knives has been employed: the operation is undoubtedly difficult, and a hope has been entertained of removing or lessening the difficulty by some peculiarity in the instruments. We need not expect to overcome the difficulties so inseparable from the operation by mechanical contrivance. One knife may

be better calculated for the purpose than another, but a beginner will not find the operation easy with any instrument, and dexterity can only be acquired by repeated practice. The particular form of the instrument is perhaps of no great importance. The method of Daviel is not employed now; he, with a sharp pointed knife, made a division in the lower part of the cornea, and then introduced a small scissars so as to enlarge the opening; this is never practised now, except in cases of necessity.

Lancet shaped knives have been most commonly employed; these are the sort of knives (showing several) which were used by Richter, Wenzel and Ware. This is a knife, (showing one,) first used by Barth, the founder of the Vienna School of Ophthalmic Surgery, and now more commonly called Beer's knife; it is straight on the back, with an oblique or slanting cutting edge, and gradually increasing in breadth as well as thickness, from the point to the handle. In my opinion it is the knife best adopted for the extraction of the cataract. It is ground lancet shaped at the point, by which means it enters the cornea more readily; but it is blunt in the rest of the back.

In making this incision of the cornea, four points are to be attended to, viz. puncturing the cornea, carrying the knife across the anterior chamber, the puncture of the cornea at the opposite side, and lastly the completion of the section downward. On entering the instrument at the temporal side of the eye, one thing to be attended to is, to carry the point of the knife directly through the cornea, not obliquely. You may pass the knife between the corneal lamellæ without entering the anterior chamber, or you may cut them so obliquely, that the inner line of the section will be much smaller than the outer, and consequently there will be not sufficient room for the cataract to pass easily. I should have before observed that the knife is to be held between the finger and thumb, just like any other knife. You rest the hand on the cheek or against the temple, and you perform the section of the cornea, by carrying the knife on with an extension of the fingers, not by moving the whole hand. To divide the corneal laminæ perpendicularly, you should carry the point of the knife, when you make the first puncture, in the direction of the iris, as if you were about to carry it directly against the iris, until you get completely through the cornea; then turn the point of the knife and carry it on with its flat surfaces parallel to the iris, across the anterior chamber. The more quickly this is done, the less chance is there of the escape of the aqueous humour. One great difficulty in performing the section of the cornea is this; when the point of the knife reaches the opposite side of the eye, the ball is involuntarily turned inward toward the nose; to counteract that, you must employ a little pressure with the fore finger; depressing the lower lid a little, and steadying the globe at the same time to prevent the eye from rolling inwards while you are carrying the knife through the anterior chamber, and opposite side of the cornea. Unquestionably the unsteadiness of the eye, the motions which a person involuntarily makes, are great impediments to the performance of this operation. You must not be afraid of touching the globe, but fix it firmly between the fore and middle finger, just while you are entering the knife, and carrying it across: when the point is brought out there is no further difficulty in completing the section. Puncture the cornea, and traverse the anterior chamber quickly and steadily, keeping your eye on the point of the knife. It may be well to touch the cornea slightly once or twice with the flat surface of the knife, just before beginning the section, to give the patient warning, and to induce him to keep the organ as steady as possible. Having entered the knife and carried it across the anterior chamber, and having brought it out at the nasal side of the eye, you must then push it gently onwards, without any remission, towards the nose, and the breadth of the knife should be such that it may cut its way out; but we generally find that a small portion of the cornea must be divided by a downward motion of the knife, unless we push it onwards, so as to wound the nose or the internal canthus; it must be done by a gentle sawing motion of the knife, immediately upon which the lid should be allowed to drop: it is safer, however, for the upper lid to fall before this last part of the section is completed, and to wait a few seconds before attempting the cut, that every spasm of the muscles may subside.

The object you have in view, is to make a clean cut of the cornea by one single incision, employing only one instrument; you thus accomplish the purpose in a manner the most favourable to subsequent speedy union. I have already observed to you, that the presence of the iris affords the principal obstacle to the easy and exact execution of this important step in the operation. The preparatory measures of fixing the lids and exposing the globe, and the act of cutting

this very sensible part, brings on a spasmodic action of the muscles, both of the globe and lids, by which the aqueous humour is quickly expelled, and the loose floating iris pushed against the knife, or even propelled, so as to bulge under its edge. If this should happen when the point of the knife has traversed only half, or even the whole anterior chamber, and the point should be completely enveloped by the iris, it will be best to withdraw the instrument, close the eye, to allow the section to heal, and repeat the operation afterwards. But, if you should have carried the knife not only across the anterior chamber, but through the nasal side of the cornea, the iris should then be forced under its edge; you may complete the section without withdrawing the instrument, although you must not immediately press it forwards, as you would then shave off a piece of the iris. Rest for a few seconds, that the spasm may subside; gently press the iris back with the fore finger, and, keeping up the pressure, slowly complete the section. As the knife advances, its broader portion enters the anterior chamber; thus the chance of protrusion is diminished, by lessening the space in which it can occur.

When the section of the cornea is finished, it may not be large enough to allow the easy escape of the lens. A common cause of failure is in bringing the point through the cornea, before it has reached the inner edge; and this arises from the rolling of the globe inwards. You may see cicatrices, in which you find that the knife has come out only a little beyond the centre of the cornea. It is most desirable to make the opening of full size at first; that is, to divide one half of the cornea close to its circumference. When, however, this is not accomplished, what course should be taken to remedy the failure? Scissars curved on the edge, and with one blade blunt at the end, have been employed. They were regularly used in the method originally proposed by Daviel, who merely punctured the cornea with the knife, and did the rest with the curved scissars. The contused wound thus made is less favourable for union by adhesion. The mode now most commonly employed, is to use two small narrow curved knives, with rounded blunt ends, one of which cuts on the convex, and the other on the concave side. With one of these, the section of the cornea may be enlarged when necessary. This method is sometimes used as the regular way of operating; a partial section of the cornea is made with a broad knife, carried across the anterior chamber, but not brought out on the other side; it is then enlarged in any eligible direction, with one of these curved knives. When the section of the cornea is finished, the great difficulty of the operation is passed; the rest is quite easy. All you have to do is to rupture the capsule of the lens. You might force out the lens without previously opening the capsule; but you would probably expel the vitreous humour with it.

The capsule is generally lacerated by an instrument called a curette, which is curved, and has a pointed extremity. You introduce this under the flap of the cornea, the convexity turned upwards, till the point is opposite the pupil; you then turn the point inwards, sink it through the capsule, and draw it from side to side, so as freely to divide that membrane, and withdraw it with the convexity of the instrument downwards.

The third part of the operation is the removal of the lens; you accomplish this by directing the patient to open the eye, and then making a little steady and gentle pressure upon the upper lid, with the small silver spoon at the other end of the curette, while you press gently against the lower lid with the fore finger, until you make the lens rise up out of its socket. You must continue the pressure gently until you see the edge of the lens rising in the pupil and distending the iris. This part of the process cannot be too gently and cautiously performed. The iris is stretched to the utmost, and appears as if it must inevitably be torn through; but it yields gradually, and allows the largest lens to escape through the pupil. Bring the upper lid over the eye, and close it immediately on the exit of the cataract, otherwise the vitreous humour may follow the lens. Sometimes the violent contraction of the muscles forces out the lens on the completion of the corneal section, and sometimes it escapes spontaneously, when the capsule has been opened. The operation is now finished: let the eye remain shut for a short time, and then gently open it to see that the pupil is round and clear, and the corneal flap in right place. The edge of the iris is often engaged in the wound; gently press on this part of the eye through the upper lid, then open both eyes to the light, and the pupil will recover; or you may replace the prolapsed iris with the silver spoon. The after treatment of the case will be subsequently considered.

If the section of the cornea have been made in the way I have described, the lens will pass through it with great facility; but it often happens that a portion

of the soft circumference of the lens remains behind, so that the pupil is not of its natural clear black colour. You are generally directed to remove carefully from the pupil or anterior chamber all such portions of the lens, and Daviel had a little silver spoon made for the purpose of fishing them out; it is generally affixed to the same handle with the curette. I consider this a very bad practice; it is essential to the success of the operation, that the lens should be removed with as little injury to the surrounding parts as possible; the repeated introduction of instruments is obviously at variance with that object, and nothing is more likely to cause inflammation, especially of the iris, than the contact of those foreign bodies with that delicate texture. It is, moreover, unnecessary, because the soft portion of lens left behind will be removed by absorption. Then, again, little forceps and little hooks have been provided for seizing and removing portions of opaque capsule. If you were to try, you could not accomplish this, or at least not without the certainty of letting out the vitreous humour; and besides, it must be seen on a little reflection, that the opening in the capsule, which is sufficient to allow the escape of the lens, must also be large enough to admit of good vision. If there were in the pupil or anterior chamber a considerable mass of lenticular substance, and it could be removed easily, let it be done; but otherwise, make no attempt of the kind.

Sometimes the vitreous humour rises up into the pupil under the edge of the cataract; and if you were to continue pressing on the globe, that humour would be forced out instead of the lens. This happened lately to myself; much of the vitreous humour came out; the globe appeared quite flaccid, and the lens did not rise: I introduced the curette, and hooked out the cataract. The case did perfectly well, although the coats of the eye fell in as if they had been completely emptied. We may hence conclude, that the escape of that humour is not to be regarded in itself as a very serious circumstance. The space which it before occupied is filled up by aqueous secretion. There is no doubt that one-fourth or one-third, and perhaps even one half of the vitreous humour may be lost in this way, without interfering with the result of the operation. In many instances it seems rather to contribute to success: it lessens the bulk of the globe, and takes off that tension which occasionally succeeds to the operation. Sometimes there is a spasmodic action of the muscles, propelling the vitreous humour against the cornea, and preventing the apposition of the flap. I have in such cases introduced the curette through the pupil, and let out some of the vitreous humour purposely.

It is desirable not to wound the iris; but a clean cut of this part is not in itself of any consequence. I have seen a portion of it shaved off in making the section of the cornea, a few times, without any injurious result; the case has proceeded much more favourably than it would have done if the knife had been withdrawn, and the section completed with other instruments. The pupil is afterwards larger, and of irregular figure.

After treatment.—We will consider, then, that the operation is finished. What should be next done in the way of bandaging or confining the eye? The treatment should be simple; our object is to keep the organ perfectly quiet, so that the corneal flap may remain in apposition, and become united by adhesion. A quiet state of the eye, and of the patient in all other respects, and the exclusion of light, are necessary for the first three or four days. The coverings of the eye should be light; a soft rag doubled and wetted in water, may be gently bound on the eye by a single narrow linen band, and the other may be covered in the same way. Recollect that the eye is naturally open to the air, and that you would create heat and great uneasiness if you were to bandage up a sound eye.

We must not, therefore, regard it as a rule, that the patient is to be bandaged. The light covering I have recommended, which we always use at this Infirmary, is rather employed to keep the eye quiet, and guard it from any slight accident, than as a measure absolutely necessary: on the latter account it is proper to have the eye covered during the night, but it might be left open, or at least with thin wet rags only on it while the patient is awake. The bandage should be immediately removed, if there is any feeling of heat or pain. It will be comfortable to the patient to have a soft sponge and cold water ready that he may moisten the rag occasionally. After the operation the patient should go to bed, and keep the head and shoulders rather high; the room should be darkened for the first few days; and the food should be soft, not requiring mastication, so that the muscles of the face may be kept quiet. The bowels should be briskly opened on the morning of the operation, so that the patient may be quiet for the next twenty-four hours, and then a mild aperient of some kind should be given, just to keep them moving, not to purge or produce much exertion. If this plan of

proceeding be adopted, and the patient goes on comfortably, we may expect to find at the end of four or five days that the cornea has united, and that the operation will have succeeded; and we generally find it to be so. The edge of the upper lid may then be carefully raised, and it will be a great satisfaction to the patient and to the surgeon to know that the eye is going on well; that there is no unnatural redness, no prolapsus of the iris, and that the pupil is regular. If we find none of these circumstances present, and if the cornea have united, we may consider that the operation has succeeded; all covering of the eye may be laid aside, or at least it will be sufficient to pin a light rag to the nightcap, allowing it to hang over the eye, or to wear a common green shade.

We then allow the patient to get up and to sit in a dark room, walking about occasionally, for about ten days or a fortnight more, still adhering to a low diet and attending to the bowels. If things go on favourably he may open the eye in a weak light, and use it more freely as it becomes stronger. After some time, generally in about a month, it is expedient that the patient should be suited with spectacles; the loss of the lens diminishes the refractive power of the organ, so that it becomes necessary to supply its place by convex glasses. The patient must select those glasses, with which he can see best. He will require two pairs of spectacles, one for ordinary vision, the other for reading, writing, and the other purposes for which accurate near sight is required; the latter must be more convex than the former. Some weeks should elapse before the patient begins to use his glasses, and he should at first proceed cautiously. Indeed he will act prudently in employing the spectacles at all times sparingly; in many cases the cataract is not the sole imperfection in the eye, and vision may decline and be lost at some length of time after the operation, without any obvious reason.

Great attention should be paid for some time to the state of bowels, the diet, and the general health; the eye should not be much used, nor exposed to strong light, nor should the patient run any risk of getting cold; the organ remains weak and irritable after the operation, and therefore liable to inflammation from slight causes.

The wound of the cornea is considerable; there is a large surface to be united and cicatrized, and numerous red vessels will be seen upon the conjunctiva and sclerotic opposite to the section; these enlarged vessels are employed in repairing the breach made in the corneal structure, just as is observed in the healing of an ulcer of the cornea.

We have supposed that every thing is going on favourably after the operation; however, we unfortunately find, as we might expect, that so large and penetrating a wound of the globe often produces serious inflammation. If the patient should not have lost blood previously by venesection, if the state of the health should not have been sufficiently attended to, or even if these circumstances have received that attention which they deserve, I make it a rule myself to have the patient bled to fourteen or sixteen ounces on the evening of the operation, unless there be a reason to the contrary; if, however, there should be pain of the eye, or head, a large venesection is absolutely necessary. This is a very safe kind of precaution; I have never seen it injurious; but in some cases I have had occasion to regret that it was neglected.

Bleeding should on no account be neglected; and it is necessary either that the operator should do it himself, or that he should intrust it to some one in whom he can place great confidence. If the bleeding should not remove the pain, or if it should recur, you should have recourse to the same means again, and the further use of cupping or leeches may be necessary. The greatest attention should be paid to the patient for the first forty-eight hours after the operation, the object being to prevent the occurrence of inflammation. It will not do to wait till inflammation arises, and then adopt measures for reducing it. If this process be allowed to take place, either the success of the operation is frustrated, or it is rendered less perfect.

When you consider the violent distention of the iris in the escape of the lens, its exposure by the large section of the cornea, and the mechanical irritation which it sometimes undergoes from the contact of instruments used in the operation, you will not wonder that iritis should occasionally follow the operation. It generally commences about the fourth day, with severe pain in the head; this pain is aggravated during the night, remitting in the day. The iris changes its colour, lymph is effused into the pupil, there is great sensibility to light, and increased lachrymal discharge. Closure of the pupil, or obstruction of it by an adventitious membrane, are its consequences if it is not arrested. Free venesection in the beginning, when the pain is first felt, cupping and leeches, and afterwards the active use of mercury, are the best means of

combating this affection. But the latter remedy is not so efficacious here, as in iritis from internal causes.

I have described extraction as it is performed on the left eye, with the operator's right hand, the inferior half of the cornea being divided. The operation on the right eye is the same, except that the operator must use his left hand. This has been considered very difficult; but you will find, in practising on the dead eye, that it is just as easy as the use of the right hand; and you will meet with no greater difficulty on the living subject.

The upper half of the cornea may be divided instead of the lower, and some prefer this plan. It is most conveniently executed with the patient lying, and a common couch serves the purpose very well, the end being about the proper height for the patient's head. The operator is seated behind the patient, and employs the right hand in operating on the right eye: he elevates and fixes the upper lid for himself, and as this almost sufficiently exposes the globe, he hardly wants an assistant. The advantages of this operation are, that the operator has a more complete control over the globe; he can fix it very perfectly; that the aqueous humour does not escape so readily, and consequently, that the section of the cornea is more easily accomplished; that there is less chance of prolapsus iridis; and that the upper lid keeps the flap of the cornea in exact apposition.

LECTURES

ON THE

THEORY AND PRACTICE OF PHYSIC,

By DR. CLUTTERBUCK.

Theatre, General Dispensary, Aldersgate street.

Lecture XXXIX.

Of Hæmoptysis, or Spitting of Blood.

Gentlemen,

Hæmoptysis, or hæmorrhage from the lungs, is deserving of your attention, more on account of the alarm which it occasions, than from the real danger of the disease; for, in itself, it seldom proves fatal. The danger arises rather from the disorganized state of the lungs, upon which, in most cases, the hæmorrhage depends, than upon the mere loss of blood, which is seldom so great as to endanger life. This hæmorrhage is liable to be confounded with *hæmatemesis*, or vomiting of blood, where the blood comes from the stomach: but the distinction is, in general, sufficiently easy.

In *hæmoptysis*, the blood discharged is generally fluid, and of a florid hue; it is often frothy, likewise, from the intermixture of particles of air. In *hæmatemesis*, the blood is generally coagulated, and grumous or dark coloured. The attendant symptoms are also different in the two cases. In *hæmoptysis*, the blood is brought up by coughing, and there are generally other signs of disease in the chest; such as pain and difficulty of breathing; but in *hæmatemesis*, there is commonly pain and other signs of disorder in the stomach and neighbouring parts.

Theory of Hæmoptysis. There are many varieties of this affection, depending chiefly upon the part from which the blood flows. It may take place from the mucous membrane, as in cases of catarrh, from the rupture of a small vessel during the violence of coughing; or possibly in the way of secretion from the membrane. In this case, the quantity of blood lost will be small. Or it may take place from the lungs themselves, when the quantity of blood lost will be larger, though in very different degrees; and it may occur under different circumstances. Thus, it may take place from mere fulness of habit; or from violent exercise, which acts by increasing, inordinately, the circulation through the lungs; or, it may be vicarious with some other habitual discharge that has been accidentally suppressed, as in deficient menstruation. In these cases, it is difficult to say whence the blood proceeds; whether from the *bronchial*, or the *pulmonary* artery. Judging from the very florid appearance of the blood, it would seem to come from the extreme branches of the latter, or, possibly, the pulmonary veins; the blood appearing as if it had recently undergone its destined changes. Hæmorrhage from the lungs also is frequently a mere symptom or effect of ulceration in those organs; and hence, frequently takes place from time to time, in pulmonary consumption. *Hæmoptysis*, lastly, may arise from the bursting of an aneurism into the bronchia; this is likely to be followed by instant suffocation, and will be preceded by the usual signs of aneurism, in the chest.

The *prognosis* in *hæmoptysis*, is very different, according to the circumstances inducing it. as I have just pointed out. If it takes place without any actual disease of the lungs themselves, as when it occurs from mere plethora, or from violent exercise, or is vicarious with some other discharge, it is attended with but little danger; but, in the greater number of cases, it is preceded and accompanied by a diseased state of lungs, which is the real source of danger, and not the mere hæmorrhage. This, on the contrary, generally gives relief, by diminishing the tendency to inflammation. If there have been cough previously, or pain in the chest, or difficulty of breathing, with emaciation, the worst results may be expected, however trifling the loss of blood.

The *treatment* of *hæmoptysis* is varied by the circumstances already mentioned, and from which it proceeds. It is varied also by the habit, and other circumstances of the patient. Thus, if it is merely the consequence of plethora, the treatment is simple and obvious; consisting chiefly in *abstinence*, and in extreme cases, *blood-letting*. If it arise from the suppression of habitual discharges, these, if possible, should be restored. When it is a symptom merely of diseased lungs, this is the object of practice, the mere hæmorrhage being in general, a matter of no importance.

The ordinary treatment of *hæmoptysis*, is not sufficiently discriminate. It is usual to bleed in all cases, and that very largely; repeating the evacuation as long as the hæmorrhage continues: while, at the same time, the patient is kept shivering with cold, and almost every thing but cold water is denied him. This practice is seldom proper; at least, when carried to the extent that is commonly done, and in many cases the reverse treatment is required.

When the habit is robust, and febrile action exists: where the pulse is hard, as well as strong, and the tongue furred; there is no question of the propriety of *blood-letting* to a moderate extent. In different circumstances, this remedy is not required, but is rather injurious, by inducing that laxity of the solids, which is favourable to a continuance of the hæmorrhage. In cases where the patient is weak, the pulse soft, (however full,) and the solids altogether flaccid to the feel, instead of *blood-letting*, *astringents*, or *tonics*, as they are called, and even active *stimulants*, are indicated. I have frequently employed, in such cases, the *ammonia*, spices, and even the *oil of turpentine*, with the best possible effect.

The application of *cold*, in the extreme degree that is usually practised, is injurious, by constricting the external vessels, and throwing the blood back upon the heart and lungs. The extreme abstinence practised on these occasions, has always appeared to me both unnecessary and injurious; by lessening, as blood-letting does, the contractility of the extreme vessels. Solid substantial food is far better adapted to the laxity of solids which I have described.

Astringent medicines may be used, such as the *infusion of roses*; small doses of alum; or any others, may be used, though they are much less effective than is commonly imagined. The *acetate of lead* is perhaps more powerful, and sufficiently safe, if the dose be limited to two or three grains, three or four times in twenty four hours, and continued only for a few days. But even this is equivocal, as hæmorrahage, in so many instances, after a time ceases spontaneously. *Blistering* the chest, is a means of counter-irritation, that may possibly be of some advantage.

Of the Diseases of the Respiratory Muscles.

You will recollect that I arranged the *organs of respiration* under three general heads: 1st, The air-passages; 2d, The lungs themselves; and, 3d, The muscles employed in this office, the chief of which are the *diaphragm* and *intercostal muscles* (the muscles of *inspiration*): for *expiration* can take place in a great measure, independent of muscular power, by the mere elasticity of the lungs, and that of the cartilages and ligaments of the ribs. The diseases belonging to the two former heads, have been already discussed. We are now, therefore, to attend to those of the third head, the *respiratory muscles* the nature and actions of which you must first understand.

It is by the action, that is, the contraction, of the diaphragm and intercostal muscles, that the chest is expanded, and *inspiration* performed. The action of these muscles is partly involuntary, and partly voluntary. In ordinary respiration, they act involuntarily, and even without our knowledge. But we can suspend their action for a time, by the operation of the *will*; or we can increase it to a great extent, when desirous of so doing.

Now it is necessary to be acquainted with the *causes* which are capable of putting the respiratory muscles into action and which we shall find to be various.

1st. These muscles contract, and by so doing expand the chest, as a *law of the system*, or, in other words, because it is necessary to inspiration that they should do so. This is, in reality, all that we know on the subject; and is, probably, all that Mr. Hunter meant, when he used the expression "stimulus of necessity."

2d. The muscles of respiration are incited to act by the *will*. Hence we can suspend their action altogether for a time; or we can increase or diminish it, and that in regard either to the muscles of *inspiration* or of *expiration*. It would be more correct, however, to say, that it is the result only that is determined by the *will*, and not the means by which that result is obtained. We have no direct power of determining by the *will* the action of any muscle.

3d. *Mental emotion* powerfully influences the action of these muscles. In some emotions of mind, as fear and terror, respiration is hurried; in other states of mind, as in sadness, and when the mind is engaged in intense thinking, respiration becomes slower, and is sometimes almost suspended for a time; while, in sudden and great grief, the diaphragm is convulsively affected; as in *sobbing*. In *laughing*, it appears to be the muscles of *expiration* chiefly (the abdominal muscles,) that are, as it were, convulsively affected.

These facts shew, that the muscles of respiration are under the influence of the brain; which is further proved by the effect both of injury and disease. Some violent injuries of the brain destroy life quickly, by interrupting altogether the action of the respiratory muscles. Slighter injuries may, of course, derange or disturb the function in different degrees. So, in some diseases, where the brain is in a state of oppression, either from arterial distention, or the extravasation of blood or serum, respiration becomes slow and laborious. This we frequently observe towards the end of inflammatory states of brain, of all kinds, whether in the form of phrenitis or hydrocephalus; while, in the earlier stages of the same affections, the muscles of respiration are preternaturally excited, and respiration is quickened.

Nor are the respiratory muscles exempt from the influence of the *spinal chord*. Injuries, and, of course, diseases of the *medulla spinalis*, that are situated as high or above where the nerves are given off that supply the muscles of inspiration, interfere with the performance of this function, and that in a degree corresponding with the injury sustained, or the nature and extent of the disease.

It follows, as a necessary consequence of what I have now stated, that injuries or diseases of any of the nerves that convey the influence of the brain, or spinal chord, to the muscles of respiration, may also impede or disturb this function.

Again, irritation of any part of the mucous membrane lining the air-passages, is capable of exciting irregular action in the muscles of respiration. Thus, when the nostrils are irritated, the act of *sneezing* takes place; which consists, first, in a full inspiration of air into the lungs, and then by a violent and involuntary effort on the part of the expiratory muscles, (the abdominal muscles), the air is suddenly and forcibly expelled again through the nostrils, by which the irritating cause is likely to be removed; and where the irritating cause is applied to any part of the trachea or its ramifications, *coughing* is excited, and which is effected by the rapid and nearly involuntary expulsion of the air through the glottis.

But sometimes irritation of the mucous membrane appears to produce permanent contraction, or *spasm* of the diaphragm; during which, respiration becomes extremely constrained and difficult; as natural respiration requires a constant alternation of contraction and relaxation of this muscle.

It is the diseased states to which the muscles of *inspiration* more particularly are liable, that we are now to consider. The abdominal muscles, which are the muscles of *expiration*, have various other functions to perform of more importance; for *expiration* can take place in a considerable degree without their aid, as I before stated to you.

The diaphragm and intercostal muscles (the muscles of inspiration), are liable, like all other structures, to inflammation; and, like muscles in general, to disordered action without inflammation.

Inflammation of the diaphragm is properly named *diaphragmitis*. It was formerly called *paraphrenitis*, and is so designated in most of the older writers; upon the supposition of its being generally attended with active delirium. One sees, however, no particular reason for this inflammation, more than others, giving rise to delirium; nor does it accord with modern observation. The term *paraphrenitis*, therefore, is now generally laid aside. The diaphragm, or midriff, consists of a double membrane, the upper being an extension from the pleura; the lower, a continuation of the peritoneum. Between these, is interposed the muscu-

lar structure. Now any one of these parts may be attacked by inflammation, distinct from the rest; though, in practice, the distinction may be difficult. When the pleura generally is inflamed, the inflammation may, and no doubt often does, extend to the covering of the diaphragm; which would probably in addition to the ordinary signs of pleurisy, give rise to pain in the direction of the diaphragm, increased upon deep inspiration. If the peritoneal covering were the part inflamed, we might expect to find disorder in the abdominal cavity. In either case, the muscular part of the structure might be affected so as to disturb its action, and that either *spasmodically* or *convulsively*. That the muscle itself of the diaphragm is liable singly to inflammation, can hardly be doubted, from analogy; but it is not likely that we should be able to distinguish such a case in actual practice. Such minute distinctions, however, if they could be made, would be of no practical utility; the treatment being in all cases the same; namely the common antiphlogistic treatment, modified as in other inflammations, by the different circumstances I have so repeatedly pointed out to you.

The diseases of the diaphragm that take place independent of inflammation, are *spasm*, and *convulsion* or *hiccough*, as it is termed.

Spasm in this muscle occurs as a symptom of tetanus; and probably in many other cases of disease, as a secondary affection. It is characterized by pain, extending across the body at the margin of the chest; and by straitened respiration. Such cases in practice require only attention to the primary disease.

A *spasmodic* affection of the diapnragm, combined, perhaps, with a similar affection of the intercostal muscles, sometimes takes place periodically, and constitutes one variety of *asthma*; as I shall soon have occasion to notice.

A *convulsive* action of the diaphragm is termed *hiccough*, and is sometimes a sign of inflammation in this organ; when, of course, it will be accompanied with the usual characters. It frequently occurs, likewise, as a symptom of other diseases; particularly, inflammation in the abdomen; also, in brain-affections, as in fevers, in which it every now and then appears. It is produced likewise by repletion simply, or a disordered state of stomach; and it may be occasioned by irritation or distention of the lower part of the œsophagus. When hiccuping takes place as a symptom of inflammation, either in the brain or elsewhere, it is usually considered an unfavourable sign; but it is by no means a necessarily fatal one.

In the treatment of *hiccough*, regard must be always had to the cause, and particularly when it arises from inflammation, as the means that are calculated to put an immediate stop to the convulsive action, such as *anti-spasmodics* and *opiates*, may not be the best adapted, or even admissible, with respect to the inflammation ont of which it arises.

The diseases to which the *intercostal muscles* are liable, are either inflammation or spasm. Inflammation here may be of the rheumatic kind, and will then probably be accompanied with rheumatism in other parts. A state of *spasm* in these muscles, gives rise to those intolerable *stitches* in the side, as they are called, which are often induced by violent muscular exertion. It takes place also in many cases of pleurisy, and is the cause of those temporary aggravations of pain that occur in this disease. While endeavouring to relieve the spasmodic affection in these cases, you are to be careful not to employ means that will aggravate the inflammation itself. It is necessary I should observe to you, that most of the slight pains in the side that are frequently attributed to *spasm*, are in reality cases of inflammation, and should be treated as such.

In my next lecture, I propose to treat of *asthma*, properly so called.

FOREIGN DEPARTMENT.

BIOGRAPHY.

ROYER COLLARD.

Antony Athanasius Royer Collard was born in the year 1768, and after receiving his elementary education was nominated to the Chair of Humanity, at the Oratoire of Lyons. About the commencement of the Revolution he published a political journal, under the title of the *Surveillant*, which he was obliged, however, to abandon; he then betook himself to the army.

It was not till he had reached his 27th year that he commenced the study of medicine, at Chamberry, and not till he was 35 that he took his degree. At this

time he published his Thesis on Amenorrhœa.

Shortly after this period he busied himself in endeavouring to unite the Academie de Medicine, Societé Academique, and Institute de Medicine, which was finally effected under the title of the Athenée About this period he contributed a good many articles to the Bibliotheque Medicale.

In the year 1806, he was nominated first physician to the Asylum at Charenton; in 1808, inspector general of the University; and in 1812, to the Commission appointed to examine the papers that were presented to the Concours on the Croup.

In 1816, he was unanimously called to the Chair of Legal Medicine by the Faculty of Paris, on which subject he continued to lecture till 1819, when it was resolved, that a new Chair should be founded for the treatment of mental alienation. This chair was given to him.

At the period that the school was suspended, he was obliged to give up the title of Inspector General of the University; the lectures on the pathology of mental diseases were suppressed, and the office of physician to the institution of Alfort was taken from him.

When the school was re-organized, Mons. Royer Collard was again nominated to the situation of Professor of Legal Medicine. He died in consequence of a disease contracted from studying in a damp room. The following character of him is given by his biographer, Monsieur Jolly:—

"He was a model of talents and philosophy, virtue and probity, preferring always the treasures of a good conscience to the treasures of fortune; and when about to descend to the tomb, he was able to contemplate both his public and private life without accusing himself of a single action that could spot his character."

M. Adelon has been nominated his successor.

His works are those we have already mentioned, and the following that are unpublished:—

An Essay on Psychology, as an Introduction to the Course on Mental Pathology.

Course of Legal Medicine.

Several Memoirs on Mental Alienation, that are about to be published.

A Monograph on Croup.

PHYSIOLOGY.

Meding's and Kortum's Experiments on the Reproduction of Bone.

In our last Number we give an account of the experiments which had been made on the regeneration of bone, to the time when Meding and Kortum took up this interesting subject. Meding* observed with great care not only the process which nature followed in fractures of bones and wounds, but removed large pieces from the substance of the bone, and, like Charmeil, effected artificial necrosis. After the removal of a piece from the parietes or whole substance of the tibia of a dog, Meding saw, after the lapse of twenty-four hours, a deviation of the vessels in the medullary canal from their straight course, and an inclination of them to the holes in the bone, where they became connected with those arising from the circumference. The excavations in the bone were now filled up with a gelatinous substance, which afterwards assumed the character of cartilage. The soft integuments round the excavations of the bone began to swell, and on the inner as well as outer surface of the bone, new ossific matter was deposited. The exuded gelatinous substance gradually underwent all the changes which were found in the healing of fractures; it became thicker, similar to cartilage, and contained vessels which could be injected. On the tenth day the nucleus of bone developed itself, which was streaked with numerous arterial vessels, and on

* De Regeneratione Ossium per Experimenta illustrata cum tabulis æneis Lips. die XXIII. M. Sept. 1823.

the fortieth day the ossifications of the intermediate substance was completed.

Experiments on the reproduction of necrotic bones he instituted on hens and cats. In the last, the same appearances were observed as in the former, with this exception, that suppuration sometimes came on, which was not the case with birds. In horses the experiments failed, since the reaction in these was so considerable that they died in the first eight days, from profuse suppuration. After amputation of the lower end of the tibia, and the destruction of the medullary structure; and after filling up the canal with foreign bodies, he found in the space of twenty-four hours, the wounded limb very much swollen, the cellular membrane thickened, and filled with an albuminous lymph; the periosteum was inflamed, intersected with a number of vessels, easily separated from the bone. On its inner surface there could be observed lymph of a reddish brown colour, easily drawn into threads, and which by the fifth day had assumed the character of jelly. On removing the superior layer of this mass, some delicate fibres of ossific matter came to view, connected together, and to the cortical part of the bone, by a delicate cellular membrane; these every day became more apparent, so that on the tenth or fifteenth day, the growth of the new bone was finished. In reference to the circumference, it exceeded three or four times that of the old bone; the surface was irregular where the muscles and tendons were in contact with it, and in some places thicker than in others. The periosteum in some places adhered very closely to the bone, and if this membrane were removed with force, a great number of small points could be observed, shewing the places at which the vessels entered into the newly formed substance. On dividing the new bone surrounding the old, the inner surface of the first was found cellular and reticular, but the external was of a much firmer consistence. The surface of the old bone was rough and indentated.

After the periosteum had been destroyed and the soft parts united with the bone, Meding found within twenty-four hours the rudiments of the periosteum intimately connected with the cellular membrane of the muscles, the bone covered with a reddish lymph, which gradually underwent the above-mentioned changes, and became converted to bone. After Charmeil's example, he deprived the bone both of the medullary and the periosteum, and found the same results; the bone died in its whole extent, and became surrounded with a new ossific texture, which was intimately connected with the neighbouring muscles. Contrary to Boyer's opinion, Meding considers the re-production of the bones of the cranium quite possible, and his opinion was confirmed by two cases in which regeneration of part of the bones of the head, that had been previously destroyed by necrosis, took place.

From these observations Meding concludes, that in an *external necrosis*, where the periosteum and the soft part are *uninjured*, the decayed bone will be covered by a new bone, formed entirely from the periosteum. If, however, the periosteal covering and the soft parts are destroyed, and the bone laid bare, granulations spring up from the substance of the bone itself, which only produce an imperfect reparation, so that a deepening or hollow remains behind. In the *internal necrosis*, the formation of the new substance commences from the periosteum, and becomes united with the cortical part of the bone, so as to form one solid mass, without it (the old bone) either swelling or expanding to assist in the re-production. Lastly, if a portion of bone dies in its whole extent, the new will be formed round the old bone, from the periosteum; in all the cases in which the dead bone remains covered by the periosteum, it never retains its smooth surface, but becomes diminished in size and rough on its exterior.

At the same time Meding was occupied with his researches on the regeneration of bone, Kortum* was performing experiments on animals to ascertain the same point. As Kortum was ignorant at the time when he performed his experiments of Meding's results, his labours are particularly valuable, inasmuch as they coincide with those of Meding in every main point. Kortum relates in his excellent inaugural dissertation several experiments performed on geese, hens, and rabbits, and two cases—the one was a patient in the Charité at Berlin, who laboured under necrosis of the tibia to a considerable extent, and was quite healed;

* Dissert. inaug. physiol. proponens experimenta et observationes circa regenerationem ossium. 1821. Berolini. cum tabulis æneis, 4to.

the second was an account of a horse, in which the *scapula* had been reproduced; the newly-formed scapula was inclosed in a sheath formed by the old bone. This preparation is contained in the museum belonging to the Veterinary College at Berlin, and only one similar specimen exists, which is deposited in the Museum at the Veterinary College of Alfort.

PATHOLOGY.

Curious case of Phlebitis. By Professor Cruveilhier.*

The pathological appearances in this case were discovered by Professor Cruveilhier in a very singular way. In attempting to find the femoral artery in the middle third of the thigh, considerable difficulty was experienced in separating the sartorious from the adductor magnus. As he attempted to destroy the adhesions, he penetrated into a cavity, from whence there escaped a quantity of pus, of a reddish colour, and somewhat viscid consistence.

This was supposed at first, to be one of those deep-seated muscular abscesses so frequently arising after rheumatic affections of the thigh. Before proceeding to the dissection of the parts, attempts were made to ascertain, a priori, the presence of this secretion, but no fluctuation could be felt.

After the skin had been raised, the vena saphena interna was found to have its calibre double the usual size, without diminution of its thickness. The femoral vein immediately under Poupart's ligament, being exposed, it was found perforated all over, and very much lacerated. The vessel contained a quantity of pus, of a reddish and viscid nature, completely analogous to what had been found on its exterior surface. The disease did not extend farther than to the parts where the vessels pierce the adductor. The cellular tissue which united the vein and artery, was dense and brittle.

The femoral vein examined from the crural arch was found to be three times the calibre of the artery; a concretion in the form of a red and dense membrane, lined the sides of the vessel, and in some parts the vessel was filled with pus. The popliteal vein was very voluminous. Its sides had acquired double their usual thickness. They were incapable of extension, and were lined by a reddish clotted membrane, within which there was puriform matter.

The cohesion and fragility were not circumscribed to the cellular tissue, which surrounded the vein and artery, but were observed in the whole of the adipose tissue in the ham.

Numerous cases attest that the veins enter sometimes spontaneously into suppuration, but this instance that has been detailed appears new in one point, namely, that the veins can produce solution of the continuity of their sides and deposition of pus into the surrounding substance. But did the phlebitis in this case precede the inflammation of the muscles? Taking all the circumstances of the case together, the affirmative, we think, may be asserted.

In reading the numerous cases of phlebitis that have occurred lately, only two examples can be found where the pus of the vein communicated with a cavity having a similar secretion. The one is given by Mr. Travers, who found the suppuration surrounding the jugular vein; the other is by Dr. Raikem, who saw the common iliac vein of the right side changed into a sort of narrow, ligamentous canal, communicating with a purulent cavity on the right side of the bladder. The femoral vein was completely destroyed as far as the ham, and its place occupied by pus.

As inflammation of the vein is generally followed by greater disorganization, it becomes a question whether redness is not more the consequence of dilatation and repletion of the venous than that of the arterial capillaries. *Has phlegmonous inflammation in general its seat in the minute termination of the veins, and is not pus poured out by the minute and lacerated termination of the veins?*

* Nouvelle Bibliotheque Medicale, Mai, 1826.

SURGERY.

Antiquity of Contagious Ophthalmia.*

In a new edition of the works of Plato, which has lately appeared, it would seem that contagious ophthalmia existed even in the time of this great philosopher; that is to say, 400 years before the birth of

* Hecker's Annalen, December, 1825.

Christ. In speaking of a man who had been attacked with a peculiar kind of sensation,* he is represented to be like "an individual who had received a disease of the eye from another," (ὅιον ἀν' ἀλλου ὀφθαλμιας ἀπολελακως.) It must be confessed, that this sentence does not exactly indicate the nature of the complaint here meant, which must be a matter of doubt, more particularly as the ancients attached no such distinct idea to the word ophthalmia as we do at the present day; yet from the disease being communicated from one man to another, we may conclude that this must have either been produced by some miasmatic or contagious medium. That it was not owing to a traumatic or chemical cause, may be gathered from the context.

Professor Hecker, the editor of the journal from which we have extracted this fact, and one of the most learned medical antiquarians of the day, has given us an extract from Aetius of a fragment of a Theodotius Severus, an ophthalmologist, probably of the third or fourth century, but who is otherwise altogether unknown. This extract would seem to prove, that the ancients were much better acquainted with the puriform discharges of the eye than we have hitherto been inclined to allow. "Τραχωματα or δασυματα, arise from a mild chronic purulent discharge from the eyelids, after the long continued abuse of collyria (ἐκ ρευματος πολυκρονιου αθηκτοτερου τυγχανοντος,) or without any apparent cause. The consequence is, that small tumours arise on the inner part of the eyelids, and the disease is very intractable. Δασυτης and τραχυτης are different, according to the stage of the complaint. The latter of these two is more painful, and the excrescences are larger; both are attended with discharge. Συκωσις is this disease in its highest degree. Τυλωσις is the chronic τραχυτης, passed into a state of callosity."

This clearly points out the forms and grades of this disease, and that Severus had seen it, not at any one particular period, but during its whole course. He disapproved of meddling with the eyelids with instruments and fig leaves, and employed several very excellent remedies.

"Whence is it that an ophthalmologist (οφθαλμιων) communicates this disease easily to the eye of a sound person?"—From this question, which Alexander Trallianus* makes in the 6th century, it would appear, that the ophthalmo-blennorrhea was believed capable of being communicated to the sound eye, and that formerly this disease was well known under the general name of οφθαλμια and lippitudo. In another part of Trallianus's works the infection of ophthalmia is compared to the infection of phthisis and itch.†

THERAPUTICS.

Acupuncturation.‡

M. Roux has lately employed this remedy for paralysis of the lower extremities, produced by curvature of the spine. He thrust a needle *through the spinal chord*, (the part is not mentioned,) and brought it into contact with the wires of a voltaic pile. The consequence was, the girl recovered the use of her limbs, of which she had been deprived for several months.

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* Phaedrus Steph. 256.

* Aristotelis Alexandri et Cassii Problemata et Francofurti, 1585. 4to. L. 1. No. 35. p. 258.

† I. II. p. 312. B.

‡ Nouvelle Bibliotheque Medicale, Mai, 1826.

FEVER IN IRELAND.

Dublin, Aug. 26, 1826.

DUBLIN might at present, without any exaggeration of language, be called the "City of the Plague." Within the last few days I made a tour of the various Fever Hospitals and temporary encampments, and the scenes which they present are awful beyond description. It is difficult, indeed, to convey an idea of the extent to which disease has spread, without exciting unnecessary pain in the minds even of those removed to a distance from the theatre of this dreadful visitation. The numbers afflicted far exceed the notations in the history of any of our former epidemics. To behold from three to four hundred human beings in one institution, reduced to utter helplessness, and with the ghastly attributes of death impressed on their visages, is an appalling spectacle under the most favourable circumstances: but when it is recollected that the majority of these patients are supposed to have been brought to this condition from want; that they form but a small proportion of, and that their state is comparatively better than, those persons affected throughout the city; and that should they escape disease, they have neither the means nor the prospect of fostering the almost extinguished spark of life through the tedious hours of convalescence, consequent to a recovery from fever—the reflection is overwhelming. The only deduction to be made from this frightful scene of misery is, that the malady which produced it is of an unusually mild character, the average mortality in Cork-street Hospital not exceeding one, I believe, in fifty cases, while in other years it was as much as one in twelve. The symptoms, seldom violent if noticed in time, require but rest, gentle aperients, acidulated drinks, and proper regimen, for their removal. During the last week, however, dysentery has appeared, and promises to be still more troublesome, and perhaps fatal, than fever, with which it is in some instances combined.

In the commencement of these complaints, they were principally confined to the lower, but of late I perceive that they have broken out in the higher orders of society, some medical men having already become their victims. Various causes have been assigned for the existence of these maladies; but I must acknowledge myself not one of those in the secret of their causation. At least no solution of the question which I have as yet seen, is reconcileable to my notions of cause and effect. There is a something in the problem which it is not easy to understand. We certainly have had as warm weather, and nearly as much starvation at other periods in Ireland, without being followed by such a quantity of disease. Some find a satisfactory explanation of these evils in the temperature of the air, others have recourse to the public distress to account for these phenomena, and they may no doubt depend on the united influence of the atmosphere and of inanition But if the epidemic had occurred, as it did on other occasions, in a cold season of plenty, we should then have the atmospherical philosophers flourishing both ends of their "Farenheits," like true born Hibernians, contending with either extremity of their sticks For my own part, I have little faith in the thermometer, having seen but too much disease prevail in the country at every degree marked on that instrument, from the freezing point to seventy-six. That hunger has had something to do, if not in the production of the fever, at least in its extension, I am inclined to believe, from the simple fact of a dietetic plan of treatment being more efficacious than one of a purely medicinal nature This opinion is further corroborated by the reluctance of the patients to quit the Hospitals after recovery, having little hopes of preventing relapses by a supply of provisions on their return to their homes.

The local government have taken much the same view of the subject, and are now about appending soup-shops for the distribution of such articles of diet as those dismissed from the Hospitals are supposed to require. They are also fitting up other establishments for those who cannot find beds in the other institutions, but they seem to be as long about preparing them as Noah was in building the Ark. It is well if the deluge be not over by the time that the bark is ready for sea, though it did not require the assistance of inspiration to know that many of the poor, from their wretched condition for the last three months, must have perished, if some adequate aid had not been afforded in time. There are barracks I believe about Dublin for six or seven thousand men, and I have seen in the newspapers not long since "Barracks to let," in other parts of the country. The application of one of these vast piles of building to medical purposes, might have superseded the necessity of repairing old houses for the reception of the poor, and prevented the rain, which is falling here in torrents as I am writing, from turning Lord Wel-

lington's generosity into ridicule, in ordering the tents in the military stores for the protection of persons whose condition renders them more susceptible of changes of weather, than the red-coated idler lounging in comfortable dwellings.

I should conclude here for the present, but that I perceive Doctor Maclean has misunderstood some announcements on this subject, in the Irish newspapers. Addressing himself to the Editor of the "Globe," (the only English journal that treats Irish affairs as the people wish them to be discussed,) he says, "In the extract from the Dublin Evening Post of Tuesday, inserted in your journal of Friday last, we find the truth of this remark (the evil tendency of a belief in contagion,) strongly illustrated." "For some weeks past," says a medical statement quoted, "the fever hospitals in Dublin have been unable to receive the patients claiming admission; they are all crowded to excess, and from the multitude of sick poor thereby detained in wretched habitations, we cannot but fear that the contagion must spread with rapid strides, and eventually reach (as it formerly did,) every other class of society." "Now what is the tendency," exclaims Dr. Maclean, "of this doctrine, but to alarm with an ideal danger those classes of society who are in a condition to exempt them from the consequences of poverty and distress, and to prevent them from granting assistance or administering relief in person, to their less fortunate and diseased neighbours? Of this fact we find proof in the very next sentence." "Frequently do we see ten or eleven wretched beings crowded in a cabin not fourteen feet square, with but one, or at most two miserable beds of straw to receive them. Frequently are the father, mother, and several children, stretched on the same bed, all afflicted with fever, *abandoned to their fate, and without a being to hand them a drop of water*." "Here you have a true picture of the pernicious effects of the insensate dogmata of the schools pervading the minds of the people. They not only desert, but they expel their sick friends and neighbours from society, when they stand most in need of consolation and support.*** It is not only in private society, but in the hospitals, that the destructive effects of this extraordinary faith are to be met with, for even their doors are closed against the admission of these patients, according to this statement." I am obliged to abridge the quotation, and to be brief in my remarks on it from want of space, but enough remains to show with what caution the deductions of Doctor Maclean ought to be received by the public, to whom it should be observed, he always addresses himself on questions of which they must be necessarily ignorant.

To begin then with his construction of the first paragraph from the D. E. Post, no man, I believe, but Dr. Maclean would assert that "exciting an ideal alarm" in the minds of the rich, would prevent them from assisting the poor. On the contrary, to "excite an alarm of danger," whether ideal or otherwise, of their own safety, would be the best possible means of extracting pound notes from their pockets. In the next place, their "condition" does not exempt them from disease, as I have before stated, and I believe it is not usual with them to attend "in person," on their poor neighbours, more particularly as they can readily find substitutes to do that business for hire. It is pretty evident, therefore that the Doctor himself, is "ideally alarmed" on the tendency of a belief in contagion. With respect to his comments on the second sentence from the D. E. Post, he would be correct in calling the effects which he ascribes to the doctrine of contagion, "pernicious," if such effects were not resolvable into very different causes; the necessary avocations of the poor, satisfactorily accounting for the "abandonment of the sick," put forward in the Newspaper. In supposing that the people believe in contagion, on the authority of the Schools, he is equally distant from the truth, for every one who ever read a page of history, is aware that the people believed in contagion before such a thing as a School of Medicine existed. It is, therefore, more likely that the Schools have imbibed these "insane dogmas," originally from popular opinion, than that the people took them in trust from the Schools. With this erroneous conclusion, he takes leave of his text in the D. E. Post altogether, and rises, regardless of all consequences, into the regions of fiction, when he asserts that the people not only "desert, but expel their sick friends and neighbours from society." Until informed of the circumstance by Dr. Maclean, I was not aware that the panpers of Dublin were invested with power of expelling their neighbours, *ad libitum*, and I am sure that these poor people never dreamt of usurping the Sheriff's wand, whatever drove the idea into Dr. Maclean's head. He may rest assured, however, that no such illegal practice prevails amongst us; and that sunk as we are in barbarism, and destitute of feeling as he would represent us, that not a being in Dublin has died of popular apathy, and that the great principle of British law, "every man's house is his

Castle," is inviolably observed in Ireland. Improving as he proceeds, the charge of "expression" is transferred from the people to the physicians, and on the strength of an ambiguous phrase in a newspaper, states that the doors of the hospitals are closed against the sick. The physicians of Dublin have quite enough of absurdities to answer for, without being made accountable for those of Dr. Maclean's manufacture. I must, therefore, relieve them from the awkward situation in which this gentleman has placed them, by supposing them capable of such folly as closing the doors of a hospital, to shut out contagion, when every bed in their respective establishments was supplied with a generator of this imaginary agent.

In these observations I do not wish to be understood as pronouncing any opinion on the question of the contagious or non-contagious character of the fever at present raging in Dublin, my only object being to correct statements which might betray the public into false conclusions on the subject.

ERINENSIS.

To the Editor of THE LANCET.

SIR,—I am induced by the justice of your remarks on the conduct of the *Medical* Trustees of the Hunterian Museum, in excluding the *Licentiates* from the right of visiting this national collection, to call your attention to the truly degraded situation of this class of practitioners, in consequence of the illiberal policy of the College of Physicians, which seeks to exclude them from any share in the honours or emoluments of the profession. The injurious tendency of exclusive privileges need not now be discussed, but when possessed by a party who exercise them for the most selfish purposes, to the obvious detriment of their profession, and when it is sought by these means to deprive the Licentiates of that share of public confidence to which they are by their merit entitled, it is time that the constitution of the College of Physicians should be inquired into, and that the Licentiates should unite in making an appeal to the Legislature, that the obnoxious powers of the College may be abolished.

The distinction which exists between *Fellows* and *Licentiates*, arises from the circumstance of the former receiving their diploma at Oxford or Cambridge, while an individual endowed with the highest attainments in his profession, and possessed of the diploma of the most celebrated University in Europe, is only *tolerated* as a Licentiate, after an examination. The peculiar virtues of a diploma from the English Universities are admitted on all hands, but should there exist an unfortunate sceptic on this point, I have no doubt that it can be proved by your friend Dr. HEWETT, Professor of Physic of Cambridge, and Physician to St. George's Hospital, or the *Reverend* Dr. CLARKE, Professor of Anatomy at the same place, that no knowledge is sound except what is obtained from their lectures. That there is a charm, however, is beyond a doubt, from the anxiety evinced even by men of advanced years to be admitted into the College, notwithstanding the immense sacrifice of time and money which the attainment of this object requires. The *Fellows*, though not half so numerous as the Licentiates, are in possession of the patronage of the majority of the Hospitals in this Metropolis; they associate with the higher classes of society in consequence of their wealth and assumed superiority in classical learning; introduction into practice is mainly dependent upon them; in short, their influence is such that without it, success in London is hopeless, without the qualifications desired by them; nay, the throne is not exempt from their intrigues, as it is asserted that the King has promised to Sir HENRY HALFORD that the care of his body should henceforth be exclusively confided to the *Fellows* only!!

Were these distinctions founded on superiority of intellect or medical knowledge, an incitement to study would be the natural consequence, an admission into the College would be the reward of merit; but the reverse is the fact, for it is notorious that there is not a medical body equally numerous in Europe where less improvement in physic has been made; or who is there among the Fellows whose name is known beyond the pale of his practice? Should a foreigner, unacquainted with the talents required to be a member of this corporation, ask who are the celebrated physicians in London, in great practices? Will you favour me with the contributions of Sir HENRY HALFORD, Drs. WARREN, MATON, Sir LUCAS PEPEYS, or Drs. RAMADGE or AGAR, to the stock of medical knowledge which entitles them to cool obloquy; or such men as Sir GILBERT BLANE, Drs. BABINGTON, CLUTTERBUCK, HOOPER, BERKBECK, ROGET, GOOCH, HOLLAND, ARMSTRONG, WILSON PHILIP, BLUNDELL, and many others, men who confer honour upon any body to which they belong, and strikingly illustrate the wicked-

ness and folly of those who have recourse to the abused privileges of a *Charter*, to depress the merits of their rivals. But the College have, during an arduous struggle in the Court of King's Bench, admitted, that Licentiates may be received into their body, on attaining their 30th year, and being proposed by a Fellow on a certain day in the year, should he pass the ordeal of sundry *ballots*, and obtain the concurrence of the Censors. In consequence of this regulation, Drs. Cooke, Southey, and Sir James M'Gregor, have accepted the *fellowship*, in other words, are entitled to their share of the patronage of this immaculate College.

It is painful to inquire into the motives which actuate individuals in their conduct, but when strong suspicion exists that they owe their elevation to the sacrifice of public interests, and that the College has selected them to answer their own ends, the truth of such allegations may at least be inquired into. In the celebrated controversy of the Licentiates against the Fellows, Dr. Cooke took a prominent part in conjunction with Drs. Wills and Stanger, in exposing the injustice inflicted upon the Licentiates by the *Charter and bye laws*; in order to stop the proceedings, an offer of admission into the College was made, but was disdainfully rejected by the two latter; but Dr. Cooke has accepted it!!! Dr. Southey was appointed Physician to the King, he being at the time a Licentiate, but to hide his disgrace, sought and obtained refuge in this corporation. Sir James M'Gregor deserves well of the public; his department in the army yields to none in scientific or medical acquirements, the zeal he has shown is honourable to him; but when he *strongly* recommends candidates for physician to the forces, to become *Licentiates* of the *London* College of Physicians, he must have forgot the interests of those over whom he presides; but a *fellowship* is his reward. There is, however, an *impure* class of practitioners who have no hope of salvation or purification; wo betide that mortal whose hands have been defiled by the contact of the pestle and mortar, or shall in the moment of necessity have assisted a suffering female in giving birth to her child, or to that inferior being called a *Surgeon*; for them, there is no hope; even the walks of an English University cannot free them, for no Bull was ever issued by the Pope more peremptory than that they shall never contaminate the Fellows by being received into the College of Physicians.

The College of Physicians are in possession of great wealth; they have a noble edifice for their meetings, a Museum, and a highly valuable library. It shall be the object of a future letter, to inquire into employment of the advantages they possess, and the means by which they have obtained their extensive patronage; and also the injurious tendency of their Charter on medical practice generally.

In the meantime, let not the *Licentiates* forget the debt of gratitude due to Messrs. Ramadge and Agar, who, actuated by the *exclusive system* of their corporation, have brought this question before the public, and given THE LANCET an opportunity of inquiring, with his independent spirit, into the truth of the above allegations.

AN ACCOUCHEUR,
Licentiate of the R. C. of Physicians.

To the Editor of THE LANCET.

SIR,—Should the following cases be deemed worthy of a place in your columns, the insertion will oblige,

Sir,
Your obedient servant,
R. VINES.

Veterinary College,
August 5, 1826.

CASE I.—A horse was ordered to be destroyed, which was done at 11 o'clock, a. m. At the usual hour, namely, six in the morning, he was fed.

Examination after Death.—On opening the abdomen, and examining the lacteals, I found them full of a white fluid. I then opened the thorax, and exposed to view the thoracic duct; on dividing which there issued from it a white fluid. Of this I caught about half an ounce in a glass vessel, and set it aside. The following morning I found the greater part of it had coagulated firmly; the quantity of serum it gave out being very small. To this I applied heat, and found it to coagulate likewise.

All the different organs contained in the chest and abdomen were in a healthy state, with the exception of the lungs, which were slightly diseased.

Chronic glanders existed in the frontal and nasal cavities of the head.

CASE II.—A horse died of inflammation of the lungs. On examination after death, he was found to have also a chronic disease of the liver. On the peritoneal covering of which, I perceived all the lymphatics arising from thence contained red blood and were greatly enlarged. The liver itself was considerably increased in size, weighing upwards of

80lbs. The thoracic duct was full of red blood, which had coagulated in several places.

The lymphatics in all the other parts of the body were of the usual appearances.

CASE III.—A glandered horse was destroyed. On examination, the lungs were found in many parts to contain tubercles. The lymphatics arising from those parts were enlarged, and contained red blood. Those which arose from healthy parts possessed their usual appearance. I found also the left lobe of the liver diseased slightly, and the lymphatics arising from it, containing red blood; the right lobe was healthy, and its lymphatics contained a transparent colourless fluid.

The fluid in the thoracic duct was nearly as red as venous blood.

CASE IV.—A horse was destroyed in consequence of having broken knees; both joints were laid open. Previous to this he was very fat. On examining the abdomen I found a great quantity of adipose matter in the mesentery. The lacteals near the intestines were of the usual appearance, but as they passed through the lymphatic glands, they became very large, and contained red blood. The glands themselves appeared full of blood. The arteries which supply the glands, and which arise from the mesenteric arteries, were much larger than usual, as well as their veins.

The thoracic duct contained red blood. All the organs within the cavities of the chest and abdomen were in health. The intestines contained a small portion of food.

Having made secure as near the spine as possible, the mesenteric arteries and veins, above the glands; below them I took up the arteries and veins, passing a ligature around each. Opening one of the arteries, I introduced some quicksilver, which very soon appeared in the lymphatic glands, and from them passed into the mesenteric veins and lacteals, which contained red blood. From this I infer that there is a free communication between the mesenteric arteries and veins and lacteals, by means of the arteries which supply the glands.

REMARKS.—From the *first* case it appears that chyle possesses all the properties of blood, except the red or colouring matter. From the *second*, *third*, and *fourth*, that the lacteals and lymphatic vessels, are cariferous veins. That under disease they become enlarged, and carry red blood like the large veins.

THE LANCET.

London, Saturday, Sept 2, 1826.

As the commencement of another medical session fast approaches, it may not be amiss to direct pupils entering on their studies, how to employ their time and their monies to the greatest advantage. A well educated and diligent pupil can never make a bad practitioner; but he must be *well educated*, or his future success in life will be, at the best, fortuitous, and, generally, deplorable. To perfect a surgical education, there are essentially necessary, 1st. To the teacher, a complete knowledge of the subject he professes—kind, conciliating, candid manners—a desire, as well as the power, of giving instruction, and an energy that never flags; 2dly. To the Hospitals—CONSTANT ACCESS; and, lastly, to the pupil, determined and unwearied attention, and, more than all, OPPORTUNITY. It is this that makes the surgeon; and we shall endeavour to show where it is most liberally afforded, by making a few extracts from the first Number of our 9th volume, beginning with BARTHOLOMEW'S HOSPITAL, which contains 500 beds.

At this Institution, or in its immediate vicinity, the student may attend lectures on every branch of the healing art, and *visit the patients at all* hours of the day, unaccompanied by surgeon or physician. The surgeons perform their duties on different days, so that the practice of each may be attentively considered. *Post-mortem* examinations are now publicly announced; BUT there are few clinical lectures—no histories of cases—no lists of accidents, and the prescriptions for the patients are studiously concealed from the pupils!

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Middlesex—180 beds.

Pupils are admitted to the wards three times a week, *but only for a short time*, to wit, for the space of half an hour or so—just as long as the surgeons are performing their rounds, which they do simultaneously! Surgeons' books kept in the wards, *where the student may not intrude*: and the physicians' in the apothecary's shop, *which, by edict of the Governors, is equally inaccessible*. Few *knowing ones* frequent the surgeons' wards of this Institution. Southey (medicine); Ley (midwifery); Wood (chemistry); Joe Burns (operative surgery, *practically*); Brookes, Blenheim-street; Bell, Great Windmill-street.

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An Anatomical Drawing and Diagram of the Human Eye. By W. P. Cocks. Highley, 1826.

The diagram of the eye made by Mr. Cocks, contains nothing to entitle it to praise; as an engraving, it is rudely executed, and as an anatomical performance, very imperfect. The drawing is still worse; the colouring is coarse, and the power of light and shade, to represent distance, utterly disregarded: indeed, it would be impossible to say to which class of the animal kingdom the structure depicted belonged. To the letter press description accompanying the performance, we also object. Mr. Cocks has mentioned the tendinous expansion of the muscles of the globe, as a distinct coat; all good anatomists have agreed that it deserves no such appellation. Then there is the *Tunica Ruyschiana*, which is named as a sixth tunic. The evidence of Haller, Zinn, and Soemmerring, is opposed to the existence of any such structure. Soemmering, who has given the finest views of all the textures of the eye, has shown the choroid magnified twenty five times, and no such tunic as Ruysch supposed can be seen. As to the *ligamentum ciliare*, which Mr. C. says, "according to Soemmerring is composed chiefly of the ciliary nerves and blood-vessels," we have only to observe, that he never said any such thing; on the contrary, it is composed of a quantity of condensed shining cellular substance, which forms a white ring, connecting the fore part of the choroid and the outer margin of the iris to the sclerotic coat. Mr. Cocks had better have followed the example of Demours and Parr, by copying the elegant diagram of Soemmerring, which is as perfect as possible, and which we are quite sure every student would have purchased. We advise him still to do so, as it not only represents the perpendicular section of the globe, but of all the other parts which assist in forming the coverings of the eye and orbit.

A short time since we noticed the insolent conduct of the Beadles attached to St. Bartholomew's Hospital, and we are sorry to state, that the Governors have not interested themselves in the matter. These Beadles are, as we before stated, undertakers. As Beadles, they are employed to intimate the death of patients to their relatives; as undertakers, they recommend themselves to the relatives as good and honest tradesmen, and doubtless often induce those persons to believe that they have been instrumental in preventing the dissection of their departed friends. These facts fully explain the impertinent interference of these insolent servants in their attempts to prevent *post-mortem* examinations. This is a subject to which the Medical Officers of the Institution should direct the attention of the Governors.

Mr. Rose has lately tied the femoral artery, in a case of femoral aneurism. The operation occupied at least half an hour; the delay partly arose from the shortness of the external incision, but chiefly from the incision being made on the *outer side*, a la Ben Travers, of the sartorious muscle. During the operation, the external incision was *frequently* enlarged, and *from the haggled manner in which* the dissection was made, *many were the attempts to pass the ligature under the artery before the sheath was laid open.* The patient appeared to suffer great agony during the process of *pioneering*, and exclaimed to Mr. Rose, (who to him seemed more like *a thorn*,) "I think both you and I, sir, have had a hard piece of work of it!" Extensive inflammation and suppuration occurred in the sac, and throughout the limb, and the patient made a speedy exit from this world, leaving his shattered limb as another *specimen* of splendid *explorative surgery* at St. George's.

It is with deep regret that we announce the death of the once celebrated LAENNEC. It is an event which has been long dreaded by his friends in Paris, although it would appear from his own observations not at all anticipated by himself. In an early Number, we will present our readers with a biographical sketch of this illustrious physician.

"A tale told of an idiot, full of sound and fury, signifying nothing."

WE have, for the amusement of our readers, extracted from the Warwickshire Chronicle the following account of a trial, in the case of a supposed idiot; and we sincerely hope that they will be much improved by the important information communicated by the learned medical witness, Dr. PALMER. The evidence is certainly truly characteristic of an ex-editor of that highly original publication, the Mausoleum, in which we suppose there will soon appear a full statement of the doctor's novel opinions on this interesting subject:—

"Doe on dem. William Sabin v. Richard Walton, and others. Dr. Palmer, a physician, residing at Tamworth, in Staffordshire, said, when a child was born without hair, and had no hair at any future period, it indicated that its intellect would be exceedingly feeble, if not an idiot. He had seen many instances of the kind, and never been deceived. He had never known a single instance in his life of an idiot having been born with hair."

In a long cross-examination by Mr. Serjeant Vaughan, he said, he knew an idiot at Wiggington, in Staffordshire, and he had no hair; he was at that time 28 years old. It is a deficiency of the brain that causes idiocy. *A person having a very bushy head has generally strong intellects,* and a bald person, or one who has weak hair, was generally weak in intellect.* The Learned Serjeant asked him, if he ever saw his learned friend Reader without his wig, and if he thought him of weak intellect. This observation, and the fact of many gentlemen of the jury being nearly bald, produced convulsions of laughter from the auditors.

Those who have been in the habit of occasionally dosing away an hour over the pages of the Mausoleum, must have observed how anxious the editors are to direct the attention of the profession to that important branch of study—medical jurisprudence, which they seem to consider as a wide field, the cultivation of which would amply repay those that devote their attention to it. Some of its first fruits are now before the public, and we feel confident that the whole profession will come forward to congratulate the labourer on his success, and to adorn his brow, and cover his *thick shaggy locks*, with the *pyramidal crown* he so richly deserves. But the learned Doctor's renown is not likely to be confined to the medical profession, for we understand that the proprietors of the far-famed Macassar Oil are about to present him with a piece of plate, as an acknowledgment of their obligation for a discovery which cannot fail to be of such essential service to themselves; and we see, in the last puffs of their inimitable composition, that they have absolutely given an extract from the Doctor's evidence, which being an attempt to prove that all bald persons are idiots, will of course make every one extremely anxious to avert this most grievous of all misfortunes.

The Scriptures inform us, that Sampson lost *his corporeal* strength when deprived of his hair; but it was reserved for the genius of ex-editor Palmer to discover that the loss of hair had a like influence over the powers of the mind. It may be some satisfaction to Dr. Palmer to know, that Sir BILLY BLIZARD has little or no hair!!

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* We understand that the doctor's head is extremely *well covered*; our readers will be able to judge how it is *lined*.

HOSPITAL REPORTS.

HOSPITAL OF SURGERY,

Panton Square, St. James's.

The subsequent cases of ophthalmia are selected from a considerable number, which have presented themselves at this Institution, in order to point out the more striking symptoms of some of the different species of inflammation of the eye, and of the different systems of treatment which were employed for their cure.

SYPHILITIC OPHTHALMIA.

This species of ophthalmia, which only appears as a secondary symptom of syphilis, Mr. Wardrop considers to be curable, like other secondary symptoms, by three very different, and what may appear to some, very opposite modes of treatment. It may be cured by *no* mercury, by a *large* quantity of mercury, or by a *small* quantity of mercury. The latter is the plan of treatment generally employed by Mr. Wardrop, for the cure both of the primary and secondary symptoms of lues, and its good effects in the following case were most decided.

John C. ætat. 40. There is a pink coloured redness of the albuginea, more particularly around the circumference of the cornea: the vessels are seen in distinct branches coming from the periphery of the globe, and terminating abruptly at the edge of the cornea. The cornea is of its natural transparency, the pupil is contracted and irregular; the eye is not irritable when exposed to a moderate degree of light, and his vision is very slightly impaired. Complains of great pain in the eye, and corresponding half of the head and face; and also in the bones of his legs. When warm in bed, the pain is increased, and is always exasperated towards evening. There are a few copper-coloured blotches on his face and trunk. Six months ago he had a sore on the penis, and swelling in his groin, for which he used mercury, and in two months they both disappeared. In three months afterwards, a number of copper-coloured blotches made their appearance principally on the face, breast, and shoulders. Took some medicine, which nearly cured the blotches, but in a few weeks they re-appeared with nocturnal pains in the bones of his legs and arms. Soon after this his eye became suddenly affected with pain and redness, and it has since remained much in the same state. Pulse small and quick; tongue foul.

℞ *Pil. colocynth*, 10 *grains, to be taken at night;*
Ol ricini, ʒss. *in the morning.*

Second day. Bowels freely opened.

℞ *Liq. oxymur. hydrarg.* ʒij;
Tinct. opii, ʒij. M.

a tea spoonful to be taken morning and evening in a little gruel.

Fifth day. Has taken the oxymuriate morning and evening since last report, and feels the pain of his head and limbs relieved. The redness of the eye has also much subsided, and his vision clearer. Pulse natural; tongue white bowels open. Continue.

Seventh day. To take the liq. hyd oxymur. only once a-day.

Twentieth day. The eye is now of its natural appearance, his vision quite restored, and he has no febrile symptoms; tongue clean, and bowels regular, blotches greatly diminished. Still complains of pain in his ancle and shoulder joints. To leave the Hospital, with directions to go to the country, and to continue the liquor. hydrarg. oxymuriat. once a day for two or three weeks.

RHEUMATIC OPHTHALMIA.

In the two following cases the inflammation was relieved in a remarkable manner, by first administering an emetic, and then the cinchona, now sold in small doses as pointed out by Mr Wardrop in a paper on the subject, in the Medical and Chirurgical transactions.

John F. ætat. 36, a labourer. There is a great degree of redness of the white of the left eye-ball, the vessels run in distinct lines from the periphery of the globe, without anastamosing with each other, and terminate abruptly at the junction of the cornea with the sclerotica; the colour of the vessels differs from that in the preceding case, and in place of being pink is more of a yellow tint. The eye lids remain quite open, the patient not experiencing the least inconvenience from the light. Complains of great pain in the eye-brow and head. Tongue loaded and white; bowels costive.

About five months ago he had an attack of ophthalmia in both eyes, which lasted nearly a month; a few days after this, the left eye assumed its present appearance, since which the pain has been

getting worse. He has all his life been a martyr to rheumatism.

℞ *Vin ipecacuan.* ℥j.,
Vin antimon. ʒij. M.

The emetic to be taken immediately, and a calomel pill at bed time. Felt very much relieved next day, and said that he had not been so easy for several months; the appearance of the eye considerably improved; tongue clean. He was now ordered *Pulv. cinchon., carb. sodæ aa*, gr. iv.; to be taken every three hours. The redness daily diminished, and he continued the bark for six days, when the inflammation was perfectly subdued.

RHEUMATIC OPHTHALMIA.

An Irish shoemaker, contrary to the usual habits of his countrymen, got drunk, and slept during the night opposite to an open window. In the morning he complained of severe pain in the right eye, and corresponding side of his face and forehead, with great redness of the eyeball. When he came to the Hospital, which was about a week after he was affected, the eye presented in every respect a similar appearance to the one in the preceding case, with the addition of a small ulceration on the corneal conjunctiva. His tongue was foul, and his bowels irregular.

He was ordered to take an emetic immediately, and afterwards the bark and soda powder four times a day.

Under this treatment the inflammation gradually subsided, and on the 7th day the eye was completely cured.

There have been several other cases of rheumatic ophthalmia, in all of which the same general system of treatment has been adopted, and local remedies cautiously employed, or rather altogether avoided. The disease has been unusually frequent amongst all classes of society during the summer months, the warmth of the season exposing people to great alterations of heat and cold.

In cases of rheumatic ophthalmia, Mr. Wardrop has often remarked, that there is no stronger evidence of the existence of this peculiar inflammation, than the mode by which it is relieved; for none of those remedies whose good effects in common inflammation are so decided, afford in this species of inflammation any relief; whilst those remedies which afford little or no relief in common inflammation, cure the rheumatic ophthalmia. This practical observation is precisely what is to be observed by comparing the treatment of rheumatism and common inflammation in other parts of the body.

ARTHRITIC OPHTHALMIA.

Like gout in other parts of the body, gout and *rheumatism*, (*rheumatic gout*,) are often perceived so combined, affecting the eye, that it is difficult to form a decided opinion of the nature of the disease in particular cases. There are other instances where the character of the inflammation is indisputably established, as in the following, where gout was translated to the eye from a distant part.

J. Newell, æt. 67: four months ago, Mr. Wardrop performed the operation of puncturing the capsule of the lens, through the cornea in the left eye, the lens of which had been opaque. Scarcely any inflammation ensued, the greater part of the lens was dissolved, and the sight was much improved for a time. The capsule of the lens, however, by degrees became so opaque as to obstruct vision. On the 1st of August, a small sharp edged needle was introduced through the sclerotica, and the opaque capsule transversely divided in the centre of the pupil, thus forming a transparent opening. The operation did not cause much pain, a small quantity of blood was effused into the anterior chamber, but little inflammation followed. The eye, however, became rather painful, for which he, of his own accord, used cold applications. On the 9th day after the operation, he felt the great toe of the left foot stiff and painful when he rose in the morning, and the skin was of a rose colour. These symptoms increased during the day, but towards night gradually diminished, while the eye which had been operated upon became by degrees exceedingly painful; next morning the eyelids were very much swelled, and a bright redness over the whole surface of the white of the eye.

A mustard poultice was immediately ordered by Mr. Wardrop to be applied to the foot, and the following mixture, a wine glassful of which was to be taken morning and evening.

℞ *Vin. colchici*, ʒij;
Sulph. magnes. ʒj;
Carb. magnes. ʒij;
Aq. menth. pip. ʒvj.

The mustard poultice which was applied to the foot produced considerable smarting of the skin, followed by a gradual increase of the gouty pain. The symptoms of inflammation of the eye subsided in a proportionate degree. He continued to take the mixture for several days. The foot continues to give uneasiness, but the eye is perfectly free from inflammation.

GUY'S HOSPITAL.

DISEASE OF THE VAGINA AND OF THE UTERUS.

E. Cramer, 21 years of age, pallid and unhealthy in appearance, was admitted on the 5th of July, under the care of Mr. Morgan. She described herself as having had an offensive purulent discharge from the vagina for twelve months, occasionally mixed with blood. She suffered much from pain in the loins, and was very much debilitated. Dr. Blundell was requested to examine the patient; he gave the following report of her case:

"No. 5, Mary's Ward. Elizabeth Cramer labours under a *large hollow*, lying in the upper part of the vagina, and probably extending to the lower part of the uterus, almost large enough to admit a pullet's egg; the inner surface of this hollow is ragged, tender, and bleeds under the slightest handling; the vagina below is tolerably sound. The margin which separates the diseased from the more healthy organization is, in the immediate vicinity of the hollow, indurated and *scirrhous*: on the whole, the disease is malignant ulceration. *Extirpation?*—It would be difficult and dangerous. Is there a hope that the parts will heal if left untouched?

"N. B. I am not fully satisfied that the malignant ulceration is cancerous; it may as easily be dressed as any sore on other parts of the body. J. B."

There is but little to notice in the progress of this case to its fatal termination, which occurred on the 21st of August.

There was constant discharge, which was of a highly offensive description, and occasionally there was considerable hæmorrhage, large clots of blood coming away. The decoction of oak bark, with alum, was used for some time as an injection, and a drachm of the carbonate of iron given three times a day in decoction of bark. The debility consequent upon the repeated hæmorrhages eventually became so great, that the treatment was principally directed to obviate this. Stimulants and tonics were freely administered, but "tired nature" could no longer withstand the disease, and the poor woman sunk from exhaustion.

The examination of the body showed a large ulcer (or "hollow," as Dr. Blundell styles it) in the upper part of the vagina, and extending to the neck of the uterus, which was in a softened, diseased state. The ulceration had completely made its way through the vagina.

Mr. Morgan declined extirpating the uterus, as hinted at by Dr. Blundell.

OPERATIONS.

Lithotomy.—On Tuesday, August 16, Mr. Key operated on a boy six years of age. A circumstance somewhat unusual occurred at this operation. On attempting to introduce the forceps, for the purpose of extracting the calculus, the opening in the bladder was found to be filled up by the stone, and hence some caution was necessary in grasping it, in order to avoid laying hold of the internal coat of the bladder. The patient has done well.

Amputation.—On the same day, Mr. Morgan removed a boy's arm, above the elbow, in consequence of disease of the joint. The operation was performed by making two lateral muscular flaps. We regret to state that the patient died ten days after the operation.

Mr. Morgan admitted the following cases into the Hospital on Wednesday, July 26.

Males.—Abscess of the thigh; ulcer of the leg; ulceration of the mouth, from profuse ptyalism; fistula in ano; stricture of the urethra (2); scaly eruptions; abscess of the neck; disease of the knee; disease of the elbow joint; ulcer of the leg.

Females.—Ulcer of the foot; ulcer of the leg (3); abscess of the breast; disease of the toe; irritable disease of the breast; scirrhous (?) disease of the mamma.

The only cases of interest amongst the foregoing were the two last. The patient affected with the supposed scirrhous affection left the Hospital a few days after admission; the other with irritable disease of the breast remains in the Hospital. We shall notice the termination of the case.

The admission of cases by Mr. Bransby Cooper, on Wednesday, Aug. 9, was as follows:

Males.—Ulcer of the leg (2); ulcer of the foot (2); abscess under the fascia of the hand; erysipelatous inflammation of the leg; chronic enlargement of the testicle, with hydrocele.

Females.—Ulcer of the leg; disease of the knee joint; disease of the ancle joint; herpetic eruptions; hæmorrhoids; ulcerated throat; ulcer of the ancle; scrofulous abscess of the neck.

These cases do not present any thing worthy of notice.

ANEURISM OF THE ARTERIA INNOMINATA; DISEASE OF THE HEART.

J. S., æat. 54, a man of florid complexion and short stature, was admitted into Lazarus Ward, on 17th of May, under the care of Mr. Morgan. He described himself as having been ill two years, and he directed the attention of the surgeon to a tumour situated above the sternal end of the right clavicle. On examining this it was found to be a pulsatory swelling of about the size of an egg, and placed under the lower part of the sterno cleido-mastoideus, so that it could be equally well felt on either side of the muscle. He attributed the formation of the disease to a violent blow which he received on the back two years before, and he stated, that from the time of this injury he had laboured under the "beating," as he expressed it. The swelling did not appear to occasion any interruption to the functions of deglutition or respiration. He stated, however, that frequently on rising from the recumbent position he had the sensation of a ball passing up through the abdomen, which occasioned a momentary difficulty to his breathing. The pulsations of the tumour were synchronous with the heart's beat, and so forcible that they could be distinguished at a considerable distance. The pulsation in each carotid artery was also very forcible.

The heart's action was so strong as to give a strong impulse over the upper part of the chest. On applying the stethoscope, a purring sound was heard at every part of the chest, and this was also audible some way down the back.

There appeared to be one long pulsation of the ventricle, accompanied with a loud purring noise, and this was succeeded by a shorter pulsation, with less noise, at the time in which it is natural for the auricle to contract. It was inferred that both the contractions were ventricular, inasmuch as they corresponded with the pulsations of the arteries. The contraction of the auricles was therefore inaudible.

The external jugular veins were distended, but did not pulsate.

The roughened, or purring sound, which has also been compared to the noise of a saw, was distinct in the brachial arteries, but not in the radial, where the pulse was feeble and somewhat irregular.

The opinion formed on this case was, that there was an aneurism of the arteria innominata, probably involving, or rather arising, from the aortic arch. From the increased and forcible contraction of the heart, there was supposed to be hypertrophy of that organ, and from the irregular contractions of the ventricle, that there was some valvular disease. Little or no expectation of avoiding a fatal issue was entertained, but Mr. Morgan thought proper to adopt the lowering plan of treatment, acting upon the principle of diminishing the force of the circulation, which we know will prevent the increase of an aneurism, and consequently retard the death of the patient. Small and repeated blood-lettings were made from the arm, and the digitalis freely exhibited, until it produced so many unpleasant consequences that it became necessary to discontinue its use. Colchicum was afterwards prescribed, and the patient took drachm doses of the wine for some time; it had no effect in controlling the inordinate action of the heart.

July 12. The patient is anxious to leave the Hospital; he has been bled eight times, and cupped twice; the amount of blood drawn each time from the arm was about eight ounces. There is no change in the symptoms, but the disease has certainly not increased since the man's admission into the Hospital, which, Mr. Morgan remarked, under all the circumstances, was as much as could be anticipated. The patient left the Hospital on the following day.

OPERATION FOR THE REMOVAL OF FUNGOID DISEASE FROM THE SCROTUM.

The particulars of this case are as follow:—The patient is a man about forty years of age, of dark complexion, and sallow unhealthy countenance. The right testicle was removed in the month of October 1825, by Mr. Morgan, on account of fungoid disease, and in April 1826, the patient again made application at the Hospital with a fungous tumour, projecting from the right side of the scrotum. An operation was undertaken for its removal soon after his admission, and the man was subsequently discharged as cured. The disposition of this disease, however, to recur, was strongly marked, for on the 16th of August he again presented himself, and was found to have a fungoid tumour issuing from the right side of the scrotum. He stated that it made its appearance shortly after he left the Hospital from his second operation. The tumour, in a few days, became much enlarged, and there was considerable bleeding from it. Mr. Morgan, therefore, proposed to the patient that it should be removed, with a view of getting rid of a local source of irritation. The right side of the scrotum was so much diminished by the two preceding operations, that the swelling

appeared rather to come from the inner part of the thigh. In this situation, and under these circumstances, it was impossible to have any integument, and the tumour was therefore dissected out, and the wound left to be filled by a process of granulation. The disease was found to extend under the muscles, at the upper part of the thigh, and portions of that peculiar brain-like matter of fungus hæmatodes were scooped out. Mr. Morgan observed, that he had little doubt that the disease extended under Poupart's ligament into the abdomen. The undiluted nitric acid was applied to the whole surface whence the tumour was removed. The operation was performed on Tuesday, August 22.

ST. THOMAS'S HOSPITAL.

CASES OF POISONING.—USE OF THE STOMACH PUMP.

The stomach-pump has now been so frequently and successfully resorted to in cases of poisoning, and its use has become so general, that it may appear superfluous to relate additional facts, confirmatory of its utility. It is gratifying, however, so record such cases, and to reflect that the present age has given birth to an instrument thus calculated to diminish the extent of human suffering. It will be seen on perusal of the following cases, that but for its timely aid, two young women would have perished. How completely have the anticipations of Sir Astley Cooper been verified: "I certainly do expect (observed Sir A., in one of his valuable lectures,) the happiest results from the invention of this instrument."

CASE 1.—*Poisoning from Laudanum.*—A young woman was brought to the surgery, about noon, having about two hours previously swallowed six drachms of laudanum, in a fit of jealousy. The effects of the poison on the system, were very apparent; the patient had the appearance of one intoxicated; reeling to and fro, with a dull stupid expression of countenance, and an invincible propensity to sleep. The face was pale and cadaverous, the eyes dim, and the pupils insensible to the application of light. The respiration was slow and laborious, the pulse small and feeble, the surface and extremities cold.

The dresser of the week, (Mr. B. Smith,) being called to the patient, immediately had recourse to the stomach-pump, first throwing in a large quantity of water, and then evacuating it with the previous contents of the stomach. The fluid thus withdrawn, smelt strongly of laudanum. The stomach was refilled and re-emptied, and this process was continued until the fluid returned, became inodorous. After this, the poor woman was somewhat relieved; still the disposition to sleep was excessive, notwithstanding she was kept in constant motion. A strong purgative was exhibited, which acted briskly on the bowels, and in the space of a few hours there was a manifest improvement in the appearance of the patient. She became enabled to answer questions, had less drowsiness, and in fact, all the symptoms gradually yielded. On visiting her on the following morning, we found her complaining only of languor, with trifling uneasiness in the head. She remained in the hospital a few days, and was then dismissed, quite well.

CASE 2.—*Poisoning from Nux Vomica.*—This patient, a young woman, of the class of "unfortunates," was brought to the hospital about three o'clock in the afternoon, having taken, in a fit of desperation, a quantity of *rat's bane*—nux vomica.

Symptoms.—The effects produced by the poison were not continual, but occurred in paroxysms, from time to time, during which the muscular system appeared to be much affected. The patient stretched out her arms, clenched her fists, and threw her head back, whilst at the same time the jaws were firmly closed, the countenance much distorted by the contraction of the muscles, and strongly expresive of agony.

She was able to answer questions rationally during the absence of the paroxysms. The poison was taken about half an hour before her admission.

The stomach pump was resorted to, and the contents of the stomach (previously diluted) were, as in the former case, removed, and the pumping process continued for some time. The patient from this time had no recurrence of the convulsive paroxysms, and being free from any unfavourable symptom, left the Hospital two days afterwards.

On making inquiry of this unfortunate young woman, in what manner she had procured the poison, she replied that she bought it of a *practising druggist* in the Borough, by the name of Odling, and obtained it *simply by asking for a penny-worth of poison.* We were of course much surprised, and unwilling to believe her statement; that any respectable trades-

man should afford such facility for self-destruction to his fellow-creatures, as by vending pennyworths of deadly drugs, appeared to us improbable. Having, therefore, ascertained the address of the person from whom the poison was procured, we called at the shop and asked for a pennyworth of poison; and it was immediately handed over without any comment being made or question put as to the use intended to be made of it. We ventured then to inquire whether it was customary with them to sell poison thus freely. The reply was, "*Oh, yes; we sell it to any one who wants it!*" A pretty confession, truly. We have reason to believe this their statement to be correct, for one of the porters of the Hospital was directed by Mr. Green to purchase poison at this shop; he obtained it with as much facility as ourselves; and we learn that several Hospital pupils called in the course of the day, and also bought poison on the same easy terms.

Having pointed out one case as an exemplification of the melancholy consequences liable to ensue from the indiscriminate sale of poisons, we shall abstain from making any comment thereon. The practice is so glaringly vicious, indeed, that it needs none. We may, perhaps, be told, there is no existing law to prevent the sale of poisons—there is, however, a law of humanity. If a druggist can reconcile it to his conscience to distribute, for the sake of a few paltry pence, the ready means of self-destruction, or of murder, amongst his fellow creatures, we do not envy such a man's feelings—cold indeed must *his* heart be.

CASE OF STRICTURE OF THE RECTUM; WITH SOME STRICTURES ON THE CONDUCT OF SIMON PURE, AS COPIED FROM THE PHYSICIAN'S BOOK.

The following is a verbatim copy of Dr. Elliotson's report on the case of Amelia Barrows, admitted under his care, June 15th:—

"A. B., ætat. 30, ill three months; amenohorrea three months, and catamenia scanty before that period. Great discharge of yellow matter from the rectum for seven years; frequent desire of stool; tenesmus; difficult excretion, and fæces very small; passes small flat portions not larger than straws. Great pain at the bottom of the back; numbness of the extremities up to the hip, and deficiency of voluntary power; can scarcely hold her water; numbness began in the soles and extended upwards. Mr. Tyrrell to be requested to examine the rectum."

July 4. This patient has been in the Hospital from the 18th of June, and not yet examined, although directions for an examination were written on the day of admission.

8. No report yet made; the sister says the patient has been examined; that Mr. Tyrrell did not examine her, but desired his dresser to do so. Dr. Elliotson *again* requested that Mr. Tyrrell will be kind enough to examine the patient, and report the state of the parts to him.

11. *Patient not yet examined by Mr. Tyrrell!* Ordered laudanum, six minims; infusion of catechu, two ounces, to be taken three times a-day.

15. Mr. Tyrrell has now (*one month after admission*) examined the patient, and reports her to have stricture of the rectum. To be a surgeon's patient if Mr. T. thinks proper. (The young woman was subsequently transferred to the *care* of Mr. Tyrrell.)

OPERATIONS.

The only operation which has been performed of late at this Hospital, was amputation of the upper arm by Mr. Tyrrell, on Friday, August 18th. The patient was a young woman, and had been for some time under the care of Mr. Tyrrell, with disease of the elbow joint. The constitution was not suffering much, but at the patient's earnest entreaty, Mr. T. removed the limb. The joint was examined in the presence of the pupils. The ligaments were found to be much altered in structure, being reduced in some parts to a pulpy mass; ulceration of the cartilage was apparent in two places, but more especially at the coronoid process of the ulna. Mr. Tyrrell remarked, that it was highly probable the disease (if allowed to remain) would have gone on, so as ultimately to render amputation imperative. Still he did not consider the operation requisite under existing circumstances, and with this impression had endeavoured to dissuade the patient from having the limb removed.

Mr. Travers admitted the following cases into the Hospital on Thursday, July 13th.

Males—Gonorrhœa; ulcer of the leg; ulcer of the elbow; scrofulous abscess of the neck; tumour at the sterno-clavicular joint; chronic affection of the knee-joint; ulceration over the sternum; hydrocele (two cases); abscess of the testicle.

Females—Chronic enlargement of the knee joint; abscess of the leg; inflammation of the fascia of the fore-arm; venereal phagedena; disease of the womb.

The admission of cases under the care of Mr. Green on Thursday, July 20th, was as follows:

Males—Ulcer of the leg (5 cases); fistula in ano; defective motion of the shoulder joint, succeeding dislocation; inflammation of the testicle (2 cases); abscess at the verge of the anus; stricture of the urethra; inflammation of the hip joint; fistulous openings in the loins.

Females—Varicose ulcer of the leg; rheumatic affection of the shoulder joint; indolent ulcer of the leg (2 cases); inflammation of the leg.

Mr. Tyrrell admitted the following cases on Thursday, July 27th.

Males—Chronic affection of the synovial membrane of the knee joint; node; enlargement of the testicle; abscess of the neck; *pericranitis*; ulceration of the throat; chronic affection of the tarsus; paralysis of the right leg: herpetic eruption; fungoid (?) tumour of the thigh.

Females—Chronic disease of the pharynx; fungoid disease of the breast; suppurating bursa of the knee; stricture of the pharynx.

From Mr. Travers' patients we selected only two cases as worthy of notice; *inflammation of the fascia of the arm*, and a case of *venereal phagedena*. A report of the first case was given in a former Number of THE LANCET; the latter we shall take an opportunity of reporting next week, with the particulars of a case subsequently admitted.

The only case of interest amongst Mr. Green's patients, is that of *fistulous openings in the loins*, through which fæcal matter is discharged. This patient remains in the Hospital, we shall therefore wait the termination of this case.

In Mr. Tyrrell's list of male patients admitted, we find a case of *fungoid tumour of the thigh*; and amongst the females, a case of *fungoid disease of the mamma*. The latter case was reported in our last week's Number; the patient with disease of the thigh is still in the Hospital. We shall notice the sequel of this case also.

ST. BARTHOLOMEW'S HOSPITAL.

MELANOSIS OCULI.

We shortly noticed (see THE LANCET, Vol. VII. pp. 160, 222,) the case of an Irishman, on whom extirpation of the eye was performed at this Hospital in May, 1825. The patient left the Hospital apparently cured; but anxiety was felt respecting him, from the tendency to relapse, which is so frequently observed in such affections. He came to the Hospital in June last, to show himself, and express his gratitude to Mr. Lawrence; and thus we have the opportunity of stating, that he continues perfectly well. Mr. Lawrence mentioned the case shortly to the pupils, and we thus gathered some particulars not noticed in our report. The patient was little more than thirty, and the youngest person whom Mr. Lawrence has seen labouring under this formidable disease; with this exception, he has seen it only in those near to or beyond fifty. The eye had been affected nearly two years before the operation, yet the morbid structure had not appeared externally; in other instances the globe has been quite disorganized in 12 or 18 months. The appearances, at the time of operation, were, a dull dark lens pushed into the pupil, and closely squeezed, with the iris, against the cornea; a dark discolouration, obscurely perceived on the surface of the globe, at some distance behind the cornea, and covered by a close plexus of large vessels, filled apparently with venous blood; and the globe rather more prominent than the other, when compared with the eyelids closed. The preparation, now in the Hospital Museum, presented, Mr. L. stated, a very interesting specimen of the disease. The coats were filled with a soft perfectly black mass, the growth of which behind had caused mechanically the appearances observed in front of the eye.

This Irishman recommended a countryman of his to Mr. Lawrence's care. He proved to be an Albino, affected with amaurosis of one eye. Mr. Lawrence pointed him out as a specimen of that peculiar formation, and explained to the pupils the nature of the peculiarity, more particularly in the structure of the eye. From this description, and our own observations, we formed the following *description of an Albino*, who, however, would not come into the Hospital, although he had got the itch, having a large and lucrative practice in his profession—

that of fiddler, patronized by customers who did not regard that slight cutaneous defect:—

Edward Waldron, ætat. 17, a perfect Albino, was born in Ireland (county Mayo,) and came to St. Bartholomew's in June, 1826. His father has dark hair and eyes; his mother red hair, but he does not know the colour of her eyes. He has two sisters and one brother; the former are fair, the latter dark. He is stout and well made, about 5 feet 9 inches, and capable of strong exertion. There is no appearance of weakness, or any morbid tendency about him; on the contrary, he looks and is strong and hearty. His skin is fair, with a slight rosy tint, especially in the face; the cheeks have colour. The general appearance of the integuments, and that of the face, are those of a fair German, with nothing of morbid, excessive, or unpleasant whiteness. There is no roughness, scurf, or scaliness of the skin, which seems in all respects of natural healthy structure, and is not lighter in tint than in many individuals who pass unnoticed. The hair all over the body is white, and the eyelashes and eyebrows are peculiarly so. That of the head is not softer nor thinner than usual, and differs from common hair only in colour. The eyes have generally a soft and semi-transparent appearance, as if composed of unusually thin and delicate tunics. The iris is extremely thin and nearly transparent, so that we see through it into the globe; the light passes freely, and the eye is a light, instead of a dark chamber. The margin of the pupil is thicker, and very light coloured; light opaque radiated streaks extend partially from it into the iris, terminating about half way between the pupillary and ciliary margins. Only the pupil and the striæ radiating from it can be said to be coloured; the rest of the iris seems nearly transparent, and of a delicate pink tint, from the colour of the interior tunics appearing through it. The pupil, which is rather small, and varies little, if at all, is of similar colour to the iris, but darker: it is pink or rose coloured. His vision is altogether imperfect, but is not better at night than in the day, so that he has no claim to the appellation of nyctalope. He has always been near-sighted with both eyes, and that near-sightedness is now considerable. The eyes have that constant oscillating motion which characterizes congenital blindness; and the difficulty of fixing them on objects, which require a great effort, seems to be the cause of his imperfect vision. He can read, with the right eye, an ordinary print, but it gives him considerable trouble: he turns his back to the light, knits his brows, and closes the lids, leaving only the smallest aperture; he then brings the book nearly in contact with the nose. In strong light, that is, in the ordinary full light of day, he contracts the brows, and closes the lids in a similar manner, but not to an equal degree. Till within sixteen months, the left eye was the strongest, and apparently perfectly healthy: he had always used it in preference. The sight, however, has gradually failed; in the first instance, there were clouds before the eye, and objects flitting in the air: at present, he can merely distinguish light from darkness. The pupil is stationary, a little larger, and not so bright as that of the right eye.

INTERESTING CASE OF ACUTE EXTERNAL INFLAMMATION OF THE EYES, AND ULCERATION OF CORNEÆ, WITH GLEET AND RHEUMATIC SWELLING OF THE WRISTS AND KNEES.

John H——, a man of spare habit, 38 years of age, came into this Hospital, under the care of Mr. Lawrence, in consequence of the above named complaint.

On inquiring the particulars from him, we learnt that it was about six weeks after connexion that the discharge showed itself. It is now nearly two months since he first perceived it, but at no time has it been very considerable. About a fortnight after the commencement of this gleet, and whilst pursuing his usual avocations, he felt his eyes becoming very painful, as if sand had got into them; a considerable lachrymal discharge took place a very little time afterwards. He says his eyes have always been very weak and watery. The following morning after the attack, he got up to go to his work, but the pain was so severe that he could not, and about the middle of the day a medical man was sent for, who, instead of coming, *sent* poppy heads to foment the organs, and some Epsom salts to take. From this time the eyes became worse; a copious purulent discharge took place, and vision was lost. From this time the man remained without any further assistance, until he came to the Hospital.

Shortly after this attack of the eyes, he was seized for the first time in his life with rheumatic pains in the right wrist, and subsequently in the left; the joint at the same time becoming exceedingly swollen and painful. At the time of his admission, in conjunction with the severe external redness and copious thin puru-

lent discharge from the conjunctival surface, there were large ulcers occupying the central portions of each cornea. In the right ulcer, a thin transparent vesicle was observed, which at first sight was mistaken for *prolapsus* iridis; but it was only the protrusion of the membrane lining the cornea. Both corneæ were at the same time very opaque, and the left one so much so, that neither the iris nor anterior chamber could be seen. Pulse 100, quick and hard; tongue slightly loaded with a darkish fur; bowels rather confined. Ordered to be cupped at the temples to 16 ounces, and to take a dose of calomel and jalap immediately.

28. Bowels have not yet acted; ordered to repeat the powder, and to use the following lotion to the swelled wrist:

Rectified spirit, 2 *ounces*,
Camphor mixture, 6 *ounces*.

30. Since the application of the lotion to the wrists, the swelling has greatly subsided, and the pain almost gone. The right knee has, however, now become swollen and painful. Pulse 90, soft; bowels not yet open. *Ordered to have* 12 *leeches to the temples; to be cupped from the knee to* 16 *ounces; to repeat the aperient powder, and if the bowels do not act by the evening, to have an injection administered.*

May 1. The inflammation of the synovial membrane of the knee is better, and the effusion into the joint diminished. The knee, however, continues very painful. The inflammation of the eyes is less. *To take the following draught every night:*

Saline mixture, 1½ *ounce*,
Colchicum wine, 1 *drachm*.

5. An increased redness of the left eye is perceptible, and the man complains of pain. *Let six leeches be applied to the left temple, and a blister at the back of the neck.*

8. The right eye is considerably better; the cornea is much clearer, and the man says he is capable of distinguishing his fingers. The inflammation of the left eye is also better. *Continue the draught at bed time.*

12. The inflammation of the knee has subsided. He sleeps well at night, but is considerably reduced, and complains of great weakness. Corneæ getting clearer around their ciliary margins.

15. *Infusion of bark* 1½ *ounce, to be taken every six hours.*

17. He has got up to-day, but feels extremely weak. On examining the corneæ on the profile view there appears to be a superficial loss of substance, so that instead of the usual convex surface, a superficial indentation is observable. He can distinguish objects better than he could. *Let him continue the bark and have strong broth.*

19. Slightly feverish; skin hot; pulse excited; bowels open. Discontinue the bark and let him take instead saline mixture every six hours, with half a drachm of the antimonial wine in each dose.

23. Is quite free from all febrile symptoms. Still complains of extreme debility. Ordered to take an ounce and a half of the infusion of bark, with dilute sulphuric acid three times a-day.

25. Vision gradually improving, but from the circumstance of the opacities of the corneæ being in their central part, and, as a consequence, in front of the pupil and immediate axis of vision, the sight is very imperfect; but nevertheless he can distinguish objects better than he could. Continue the medicine he is at present taking, and let belladonna be applied over the eye-brows at night.

June 1. The peripheral portion of the right cornea is now quite clear, but a dense opacity still occupies the immediate axis of vision. The opacity of the left cornea is more diffused, and vision in this eye is nearly lost. The irides appear to be as yet but slightly influenced by the belladonna.

12. The belladonna was discontinued for a few nights, but has now been again repeated at night in the form of solution dropped into the eye instead of the extract. The irides now act freely and objects can be distinguished more readily; for by the free contraction of the irides, the pupil is enlarged beyond the margin of the central opacity of each cornea. The slight indentations previously observed still continue. It is probable that in progress of time these will heal, and the opacities be in a great measure removed; but as a considerable time would be requisite for this process, and as in other respects the patient is recovered, it was considered that he might be discharged.